EXPANDING INSURANCE COVERAGE AND STABILIZING RATES WITHIN THE SOUTH CAROLINA SMALL GROUP MARKET

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EXECUTIVE SUMMARY

In 2001, the South Carolina Department of Insurance (Department) completed a review of the South Carolina small group health insurance market. The purpose of the review was to address issues related to the availability and affordability of health insurance. It was also to determine why insurers were exiting the small group health insurance market. Our review determined that insurers were exiting the small group market nationally due to high loss ratios on small group health insurance products. The Department believed that the decline in the number of insurers writing in this market contributed to issues of health insurance affordability and increased the number of uninsured in this state. Although anecdotal, the review determined that most of the uninsured were 19-64 years old and the employees of small businesses. Further study was recommended because no state-specific data was available on the uninsured in South Carolina. The national statistics on the uninsured were sometimes inconsistent with the data maintained by some state agencies. It was also the opinion of many that the rate of uninsurance in South Carolina was higher than national statistics indicated.

Following a review of the status of insurance within the small group market between 1999-2001, the Department applied for and received a State Planning Grant (SPG) from the U.S. Department of Health and Human Services Health Resources Administration (HRSA) in 2002. The primary focus of the planning grant was to identify and obtain more detailed information on the uninsured population, so state policy initiatives could be formulated to reduce the number of uninsured by expanding health insurance coverage. The Department was also interested in ways to stabilize the market so that those who were currently insured did not lose their insurance coverage.

Consequently, this project focused on expanding health insurance coverage and stabilizing insurance rates within the small group market. Our grant research considered issues of affordability, increased cost sharing for employees, reduced benefit plans, decreased competition, lack of knowledge of available public programs, lack of awareness of small group insurance laws and inappropriate use of the healthcare system (i.e., using the emergency room for non-emergency healthcare). All these issues play a role in the escalating cost of health insurance.

This twenty-four month project included the formation of a Health Insurance Policy Advisory Committee (HIPAC). This Committee consisted of consumer and insurance industry representatives and health policy and insurance experts who worked with the Department's SPG team on data analysis and policy formulation. The HIPAC and SPG staff also examined existing data and collected state-specific health insurance status data through key informant interviews, focus groups and surveys.

Data Collection Activities

South Carolina's primary data collection activities are summarized in the following paragraphs. Additional detail on each of these activities may be found in Section 1. The Office of Research and Statistics, a division of the South Carolina Budget and Control Board, coordinated all data collection and analysis activities.

South Carolina Household Survey. Under contract with the Department, the University of South Carolina's Institute for Public Affairs administered a random digit dial telephone survey to uninsured South Carolinians in the Upstate, Pee Dee, Low Country and Midlands regions of the state. The Household Survey was designed to provide a demographic profile of the uninsured including: why they are uninsured; duration of uninsurance; how much they are willing to pay for insurance; race; gender; and if eligible, why they were not enrolled in public or employer-sponsored programs.

South Carolina Small Employer Survey. Two thousand four hundred and ninety-nine (2,499)[i] surveys were sent by mail to small employers in South Carolina to collect information on their ideas and perceptions about providing insurance. The Office of Research and Statistics developed this instrument in collaboration with members of the HIPAC. There was a 38.5% response rate.

Uninsured Utilization Survey. To supplement the household survey, a utilization survey was sent to a sample of 7,500 indigent and self-pay patients who use emergency room facilities. The survey was designed to obtain additional demographic data on the uninsured.

Key Informant Interviews and Focus Groups. Focus groups and key informant interviews were used to gather qualitative data. The Office of Research and Statistics, in conjunction with the College of Business and Behavioral Sciences from Clemson University, completed a compilation and synthesis of findings. The seven focus groups were conducted across the state in the same regions listed above. Additionally, SPG staff conducted 12 interviews with key informants.

Additional qualitative data was gathered through Business Forums, health benefits fairs and the National Health Insurance Symposium co-sponsored by the South Carolina Department of Insurance and the National Association of Insurance Commissioners.

Summary of Significant Findings

According to the data collected from these research activities, 21% of South Carolinians under age 65 are uninsured, and more than 8% of the population has been uninsured for a year or more. Fifty-eight percent (58%) of South Carolinians have employer-sponsored or individual private coverage; 27% have some type of public

coverage such as Medicaid or Medicare; and 11.55% are without insurance coverage at any point in time. Most uninsured individuals in South Carolina work or are the dependent of someone who works. Construction, professional, retail, service and hospitality industries have the highest percentage of employers not offering insurance.[ii] There are also more uninsured people and fewer small businesses offering health coverage to their employees in the Pee Dee and Low Country regions of the state.

South Carolina has lost a significant number of manufacturing jobs that generally offered health insurance benefits.[iii] Trends indicate that these jobs are being replaced by jobs in the service and hospitality industries where health insurance benefits are generally not provided. The qualitative data gathered through the focus groups and key informant interviews confirmed that small employers have a difficult time offering health insurance to their employees. Fifty-three percent (53%) of small employers with 1-10 employees do not offer group-sponsored health insurance. Thirty-nine percent (39%) of small employers with 11-20 employees do not offer group-sponsored health insurance. Affordability is cited as the primary reason employers do not offer health insurance coverage. Interestingly, affordability is also the reason cited by 72% of uninsured individuals as to why they have not purchased health insurance. Furthermore, 53% of eligible individuals do not enroll in public programs because they either are unwilling to accept government support or do not think the government should provide health insurance coverage.

Insurance premiums have increased significantly in the past few years. An overall increase in the cost of healthcare is one of the principal drivers; it is not the only one. The rate of uninsurance also contributes to the cost of health insurance. The cost of providing health care services to the indigent and uninsured is recovered. Uncompensated care is recovered by hospitals and providers by increasing costs. These costs are passed on to the insured in the form of higher insurance premiums. However, as the cost of insurance increases, employers drop coverage, reduce benefits, or shift more of the costs to the employee which, in turn, results in the employee's non-participation in the employer's health insurance plan thereby increasing the number of uninsured. The problem is cyclical. The increase in healthcare costs is not only affecting health insurance premiums, but it is also causing employment-based health insurance coverage to diminish.[iv]

Following the research and analysis phases of the SPG project, the SPG staff, in collaboration with the HIPAC, formulated three policy recommendations to expand health insurance coverage and stabilize rates within the South Carolina small group market. The following recommendations are proposals and therefore subject to modification:

- **Implement a Medicaid expansion program for working adults of small businesses.** This option is designed to expand health insurance coverage to employees of small employers. It will provide a statewide employment-based

insurance-like option that will cover all employees in a group plan, and provide a premium subsidy for individuals/families who fall at or below 150% of the federal poverty level.

- **Develop legislation to allow existing and new non-profit community-based healthcare programs to raise funds through prepayment fees.** These fees will be used to expand programs, increase participation, and/or increase provider reimbursement. Because each program is community based, the plan design, fees and networks will be determined based upon the community's needs.
- **Develop educational programs.** Develop and implement educational programs focusing on preventive care and other matters to help South Carolinians become healthier and better-informed healthcare consumers. This option was formulated to address issues related to cost and inappropriate utilization of emergency facilities. In addition, the website was developed to provide individuals with information about all of the community healthcare programs available in our state.

The next step is to develop specific models within the framework of the above-referenced policy options. Pilot projects will likely be developed focusing on small employers. With the creation of the Commission on Healthcare Access during the last legislative session, a mechanism is now in place to oversee implementation of these and other policy initiatives to expand health insurance coverage in South Carolina.

Recommendations for Federal Action

The HIPAC recommended several actions for consideration. These suggestions included: continued funding for State Planning Grants allowing the grant funds to be used for planning and certain developmental and implementation projects; providing increased funding to states for Medicaid and Medicaid expansion programs; simplifying the application process for waivers; clarification of the positions of the federal government on the One-third Share Plans; and, using employer/employee contributions as state matches for Section 1115 waivers. Additional recommendations are set forth in Section 7 of this Report.

SECTION 1

UNINSURED INDIVIDUALS AND FAMILIES

South Carolina has attempted to address legislatively the needs of uninsured employees and dependents of small employers by enacting the Small Employer Health Insurance Availability Act in 1995[v], and later, small employer protections under the Health Insurance Portability and Accountability Act (HIPAA) in 1997[vi]. These laws required guaranteed issuance and guaranteed renewability of policies, imposed rate restrictions, mandated guaranteed plan designs (i.e., basic and standard plans), and portability (provide credit for prior creditable coverage to prevent job lock). Each of these new mandates addressed access to healthcare. Unfortunately, none of these legislative initiatives addressed the issue of market stability or affordability. As a result, South Carolina has seen the following occur:

- A significant decrease in competition in the small group market, resulting in the loss of 55 insurers writing small group health insurance since 1997. Only 23 insurers writing small group health insurance currently remain in South Carolina.

- An increase in mandates that has increased both medical and administrative costs to insurers and providers. These costs have inevitably been passed on to employers and employees in the form of higher insurance premiums. Recent examples include external review and HIPAA privacy.

- A trend of increasing insurance premium rates and decreasing policy benefit design which has put more of the financial burden on the employee by increasing his/her out-of-pocket expenses.

- An increase in marketing medical savings accounts to small businesses to save costs. These plans need considerable consumer education: 1) on how these plans coordinate with the mandatory high deductible plan; and 2) how a patient can work with providers to ensure that the patient gets the best cost while still receiving the highest quality of care.

- More South Carolinians using the Emergency Rooms for non-emergency medical care due to a lack of insurance coverage.

This planning grant enabled the Department to collect state-specific data on South Carolina's uninsured. South Carolina's data collection methodology included a plan to study the demographic characteristics and needs of the uninsured population. The Office of Research and Statistics coordinated data collection. The Office of Research and Statistics was also primarily responsible for coordinating instrument design and data analysis. Additionally, the state's two major research universities, the University of South Carolina and Clemson University participated in the data collection activities. The University of South Carolina, Office of Research and Statistics and members of the

HIPAC, in consultation with the State Health Access Data Assistance Center[vii] (SHADAC), developed the survey instruments.

Data Collection and Analysis

The data collection methodology consisted of: (1) key informant interviews (2) surveys and (3) focus groups. The following surveys were used:

- **South Carolina Household Survey.** Two thousand (2,000) households in South Carolina were surveyed by random digit dialing.
- **South Carolina Small Employer Survey.** This instrument was administered by mail to 2,499 employers with 2-100 employees.
- **Uninsured Utilization Survey.** A supplemental sample of 7,500 emergency room and uninsured patients were surveyed by mail.

Each data collection method is more fully described in the discussion that follows.

South Carolina Household Survey

The South Carolina Household Survey (Household Survey) was the focal point of our data collection. The Institute of Public Service of the University of South Carolina administered a random digit dial population based survey. A sample of 1,600 households and 400 additional uninsured was drawn. The uninsured were over-sampled to ascertain a more accurate picture of the uninsured in the state. Interviews were conducted by telephone throughout the state. Data collection commenced on February 8, 2003, and concluded June 10, 2003, with a final response rate of 70%. Many of the conclusions resulting from this survey appear in responses to questions relating to the quantitative analysis of the uninsured.

South Carolina Small Employer Survey

The South Carolina Small Employer Survey (Employer Survey) was designed to obtain substantive quantitative data on small employers within this state. The instrument was designed to elicit information about the employer's business including the length of time the business had been in existence; annual gross revenues of the business; business location; employee wages; type of business; whether the employer offered health insurance coverage; the reasons for not offering coverage; and the maximum amount the employer would be able to pay for insurance for its employees. The purpose of this instrument was to provide a profile on the types of businesses that were more or less likely to offer insurance coverage to its employees and their geographic location. The final response rate for this survey was 38.5%.

Uninsured Utilization Survey

Additionally, the household survey was supplemented by drawing another sample of 7,500 from our emergency room (ER) and hospital databases. South Carolina maintains healthcare administrative and emergency room data. A self-administered survey was sent to indigent and self-pay patients who use ER facilities. To address the literacy issue, the self-administered survey was simplified to obtain demographic data about the household. The samples from the hospital and ER databases were surveyed to provide information

related to cost. Using the self-administered data, we tried to develop a profile of the uninsured that use the ER.[viii]

Focus Groups and Key Informant Interviews

We used focus groups and key informant interviews to gather qualitative data. The Office of Research and Statistics, in conjunction with the College of Business and Behavioral Sciences from Clemson University, completed a compilation and synthesis of findings from seven focus groups conducted across the state in the Midlands, Pee Dee, Upstate, and Low Country regions. Focus groups were comprised of small business owners offering health insurance, small business owners not offering health insurance, the uninsured and insurance producers. The following focus groups were conducted:

- 3 small employer focus groups;
- 3 employee focus groups (including one comprised of Hispanic employees); and
- 1 Producer (Agent/Broker) focus group.

Like the focus groups, key informant interviews were conducted with government and community leaders. The following representatives were interviewed:

- An insurance manager and human resource officer with a large South Carolina company;
- An administrator for a faith-based organization;
- An administrator/director for a rural health clinic;
- A health system administrator;
- An administrator for a South Carolina licensed insurance company;
- An administrator with state government;
- A representative from a community/provider coalition;
- A director for a managed care association; and
- An elected official from the South Carolina General Assembly.

Focus group participants and key informants were asked a series of predetermined questions intended to elicit responses that would explain the quantitative data received from the surveys. Additional information about the uninsured was obtained at Business Forums, the National Health Insurance Symposium, and the Health Benefits Fairs conducted throughout the state. Additional information on these activities is set forth in Section 4.

SUMMARY OF FINDINGS

What follows is a summary of our findings. For the purposes of the data summary, the following definitions apply:

"Inclusive" uninsured:	The individual does not have insurance now, or has not had insurance at any time in the past 12 months

"Current" uninsured: The individual answered "no" to all questions about insurance.

"Chronic" uninsured: The individual does not have insurance now, and has not had insurance in the past 12 months.

1.1: Overall Level of Uninsurance

In 2003, national statistics indicated that 14.4% of South Carolinians were uninsured. It was estimated that 8.9% of the uninsured in South Carolina are children under the age of 18. However, identifying the uninsurance rate in South Carolina depends upon the specific measure chosen. The broadest definition, "inclusive", treats an individual as uninsured if the individual is currently uninsured or has been at any time during the previous twelve months. Based on this definition, 19.4% of the population (774,313) is uninsured. A somewhat more restrictive definition, "current," asks individuals if they are currently insured. Using this definition, 11.6% (474,380) are currently uninsured. The most restrictive definition, "chronic," individuals who are currently uninsured and were not covered by insurance at any time during the previous twelve months. This group constitutes 8.3% (343,128) of the population. Employing the broadest definition, the rate of uninsurance in South Carolina is higher than the national average (15.6%). From its inception, the goal of this grant was to identify the working uninsured and to formulate policy options that address expansion and affordability of available insurance products to the uninsured and small business community.

1.2: Characteristics of the Uninsured

The Household Survey gathered information on the uninsured—the chronic uninsured, the inclusive uninsured and current uninsured. The Employer Survey was developed to ascertain information about the South Carolina small employer and his perceptions about providing private health insurance coverage. To develop various policy options for the uninsured, identifying the uninsured demographically was critical. The results listed below are based on analysis of the data drawn from the Household and Employer Surveys. Where applicable, qualitative data from the focus groups or key informant interviews has been included to provide nuance and texture to the quantitative data. Most of the conclusions below are based on data for the inclusive uninsured (i.e., the individual does not have insurance now or has not had insurance within the past 12 months) unless otherwise indicated.

1.2.1: Income

According to a recent article in *Parade Magazine*, most of the uninsured are between the ages of 18 and 44, and one-third of the uninsured earn at least $50,000 annually. Yet, they are still unable to afford health

insurance. The article reports that the uninsured are juggling a mortgage, the cost of their children's education, and daily household expenses. After these expenses, there is simply not enough left over for health insurance premiums.[ix] The surveys results suggest the same is true for uninsured South Carolinians. The Household survey revealed that 43.5% of uninsured South Carolinians have a gross household income between $20,000 and $50,000. Twenty-two percent (22%) have a gross household income of more than $50,000.

Figure 1. South Carolina Uninsurance Status by Income Level

2002 Gross Income	Frequency	Percent
$20,000 – 29,999	215	18.25%
$30,000 – 39,999	190	16.13%
$40,000 – 49,999	108	9.177%
$20,000 – 49,999	513	43.55%
$50,000 or more	257	21.82%

Eligibility for many of South Carolina's public health programs is determined by Federal Poverty Level (FPL) guidelines, which are established by the U.S. Census Bureau. The correlation between level of income and insurance status from the Household Survey lends credence to the qualitative responses from focus group participants that insurance is unaffordable for those with middle and lower incomes.

1.2.2: Age

The Household Survey generally showed that certain age groups are more likely to be uninsured than others. Twenty-one percent (21%) of the uninsured in South Carolina are under 65, and 17.6% were children under age 18. Most people ages 65 and older are insured due to Medicare eligibility.

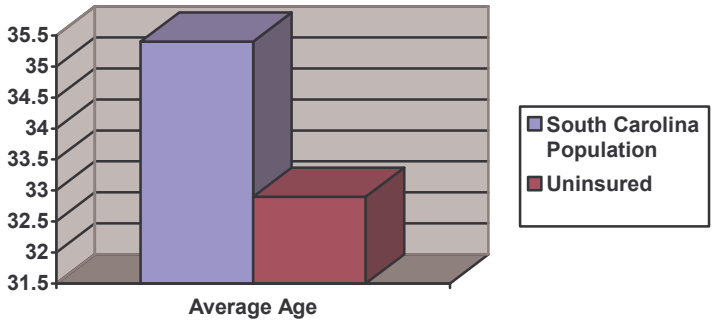
Also, according to the Household Survey, the average age of the uninsured in South Carolina is 33 years old. There was no significant difference in the average ages of the inclusive (32.79) or current uninsured (33.56). The average age of the chronic uninsured was slightly older at 35.

This is significant because it is typically the age when many people marry and start families. The qualitative responses to focus group questions indicate that health insurance is a critical benefit and is considered to be *the* most important employer fringe benefit. They also report that not having access to affordable health insurance impacts the entire family.

Studies have shown that if the parents do not have health insurance coverage, and even if the children do, the whole family is less likely to seek medical services.

Figure 2. South Carolina Insurance Status By Age

Insurance Status by Age	Average Age
South Carolina Population	35.4
Uninsured	32.79



1.2.3: Gender

For the "chronic" uninsured, the split between males and females was about 51% male and 49% females. The gender distribution for the "current" uninsured is very similar with 50% male and 50% female and for the inclusive uninsured 51% male, 49% female. Generally, this mirrors the State population percentages between men and women.

Figure 3: Inclusive Uninsurance Rates by Gender

Sex	Frequency	Percent
Male	696	48.81%
Female	730	51.19%

In addition, there appears to be no significant difference between all uninsured women and all uninsured men in South Carolina, as shown in the chart below. The national data indicates a more clear distinction between uninsured women and uninsured men.

Figure 4: South Carolina vs. U.S. Uninsurance Rates by Gender

Gender	Percent Uninsured - SC	Percent Uninsured – US
Male	19.9%	16.7%
Female	18.9%	13.9%

1.2.4: Family Composition

On average, the uninsured have three (3.37) people living on the gross household income. This is consistent with the 2000 U.S. Census data, which indicates that the average household size is 2.53 people, and the average family size is 3.02. Of these three people, on average one (1.36) is under 21 years old. We were unable to determine from the data whether single-person and multiple-person households were equally, or more or less, likely to be uninsured.

1.2.5: Health Status

Interestingly, according to the Household Survey, 83% of uninsured South Carolinians consider themselves to be in "good" health. Five percent (5%) stated that they were in "poor" health. The response to this question is based on self-perception and may not give us much insight as to why people are uninsured. However, these responses are not supported by the following South Carolina statistics:[x]:

- South Carolina ranked eighth highest for age-adjusted deaths in 1999,
- 50% of South Carolinians are obese,
- 25% of adult South Carolinians are smokers, and
- South Carolina has a very high incidence of diabetes, heart disease and asthma.

1.2.6: Employment Status

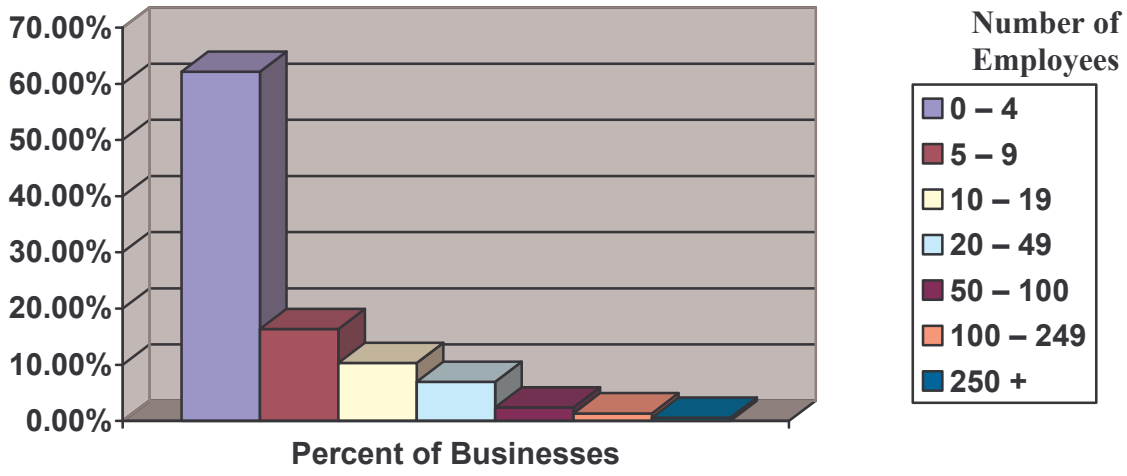
Contrary to public perception, most uninsured South Carolinians are employed. The Household Survey data showed that the majority of the uninsured were working at the time of the survey. Sixty percent (60%), or 375,732 people, were employed and uninsured in South Carolina. Unemployed adults comprised 6.3% of the population in 2003.[xi] One possible explanation for the high rate of uninsurance is that some South Carolina workers are less likely to have access to employment-based health insurance coverage. The occupational composition of the state contributes to the uninsured problem. Generally, most employers do not offer health insurance benefits to part-time, contract, temporary or

seasonal employees. This explains why certain occupations are less likely to have insurance than others. Many South Carolinians are employed in retail and other service industries that traditionally do not offer insurance benefits. The highest percentage of uninsured South Carolinians is employed in the tourism, retail and service industries.

The qualitative data received as a part of our research indicated that employers are faced with difficult financial and social decisions when deciding whether or not to offer health insurance to their employees. Premium rates are considered high and increase annually by double digits.[xii] Small employers are almost always required to pay a portion of the premium, usually at least 50%. The results of the Employer Survey indicated that small employers have to make decisions about whether to put money back into the business for future growth and profitability, or provide health insurance to attract and retain quality employees. Many business owners are choosing to cut or eliminate health insurance benefits at the risk of losing employees.

This situation is more likely with new businesses and very small businesses. According to the results of the Employer Survey, 90% of registered businesses in South Carolina have fewer than 10 employees. Fifty-three percent (53%) of employers with less than 10 employees do not offer health insurance, and 39% of employers with 11 and 20 employees do not offer health insurance. It is clear from the survey results that the smaller the employer, the less likely the employer is able to: 1) offer group health insurance; 2) afford to offer group health insurance; and/or 3) pay a percentage of the employee's premium.

Figure 5. South Carolina Businesses by Size



Another important consideration is the ability of the employee to afford his percentage of the insurance premium. Our Household Survey data showed that 72% of the uninsured listed affordability as the reason they were not insured. Thirty-eight percent (38%) of the uninsured stated that they were eligible for the employer's group health plan, but they could not afford the insurance co-pays. It is even less likely that employees can afford to cover their dependents for which they are generally charged 100% of the dependent premium.

Fifteen percent (15%) of the uninsured indicated that they are self-employed or own their own business. Because the South Carolina small employer insurance laws do not impact groups of less than 2 employees, options for the self-employed are limited to an individual plan or possibly a fully funded association plan. If a self-employed individual has a pre-existing condition, there are not many *affordable* options available.

1.2.7: Availability of Private Coverage

The number of insurers writing coverage in the small group health insurance market has declined significantly over the past seven years. The South Carolina Department of Insurance monitors insurers exiting this market to determine the reasons for leaving. The majority cites high loss ratios for small group health insurance products or other financial reasons when exiting the market. This phenomenon is not unique to South Carolina. Insurers opting to exit the small group health insurance market are doing so nationally. Despite the decline in the number of insurers writing in this market, insurance coverage is available. Coverage is available even for those South Carolinians with serious health conditions through the South Carolina Health Insurance Pool (SCHIP), the state's high-risk pool.

Availability is not the principal issue. Approximately 72% of the uninsured responded that the main reason they did not buy insurance was because it was too expensive. No other reason came close to this response. The percentage increased for a separate question that asked parents why they had not purchased insurance for themselves—80.58%. Affordability—not availability—was repeatedly cited, as the reason insurance was not purchased.

Two issues surfaced when asked why an employee was not included in an employer's insurance plan. For the "inclusive" and "current" uninsured, 38% stated it was because they could not afford it, and 32% said it was because they had not worked at the company long enough to qualify for insurance coverage. Of the "chronic" uninsured, 44% stated that they

could not afford coverage and 22% stated they had not worked at the company long enough to be eligible for coverage. These responses are not surprising. Based on the income levels of the uninsured, this group probably consists of the working poor--those employees who have low incomes or who frequently move from job to job.

1.2.8: Availability of Public Coverage

There are public programs available for certain uninsured populations such as Medicaid, Partners for Healthy Children (S-CHIP) and the South Carolina Health Insurance Pool (SCHIP). Each program has eligibility criteria. Responses to the Household Survey question "why are you not enrolled in a South Carolina public health program" were infrequent and therefore not very reliable. The two most common responses (53%) were: 1) the respondent did not want government assistance; and 2) the government should not provide public assistance.

These responses aided the design of the Medicaid expansion small employer product. Due to the apparent stigma associated with public programs, the HIPAC recommended making the product look as much like a group-sponsored health insurance product as possible.

1.2.9: Race/Ethnicity

According to the 2000 U.S. Census Report, 66.1% of South Carolinians are Caucasian and 29.4% are Black/African American.[xiii] However, unlike the national data, there does not appear to be any significant difference in the uninsured population for these two races.[xiv] South Carolina's Hispanic population is the exception.

Figure 6: Uninsurance by Race/Ethnicity

Race/Ethnicity	White	Black	Hispanic	Other
SC Total Population (Percentage)	2,714,848 66.1%	1,207,512 29.4%	98,575 2.4%	86,250 2.1%
Insured	81.87%	80.65%	57.72%	62.1%
Not Insured	18.13%	19.35%	42.28%	37.9%

Forty-two percent (42%) of Hispanics are uninsured, which comprises 5% of the state's total uninsured population. There are approximately 98,575 Hispanics in South Carolina. South Carolina has the sixth fastest growing Hispanic population in the United States.[xv] This information was extremely important to our policy development strategy and, in part, led us toward a community-based policy option. A community-based program

would allow the individual community to determine the need for its program based upon the demographics within that community.[xvi]

1.2.10: Immigration Status

Ninety-five percent (95%) of individuals responding to the Household Survey indicated that they were United States citizens. Responses for the chronic uninsured varied slightly; 92% of chronic uninsured responded they were U.S. citizens.

1.2.11: Geographic Location

We were not able to obtain credible county-specific data for all the counties in South Carolina, so we looked at the data by region. The four regions of South Carolina are classified as the Upstate, Midlands, Pee Dee and Low Country. These regions are commonly used to classify the population for data purposes.

While there are some differences between regions, it is clear that uninsurance is a problem throughout South Carolina. The Pee Dee and Low Country regions are predominantly along the coast of South Carolina. Consequently, the industries there are usually tourism and retail. As previously stated, these two industries do not typically provide health insurance to their employees and often have more part-time and seasonal employees than full-time. The rate of uninsurance appears to be higher in these regions at 20% (Pee Dee) and 22% (Low Country), respectively compared to the other regions at 18% (Upstate) and 19% (Midlands), respectively. This assumption is further evidenced in the table below. Figure depicts the types of small businesses not offering health insurance coverage by region.

Figure 7: Small Business Not Offering Health Insurance by Region

Small Business Not Offering Health Insurance	Percent
Upstate	16%
Midlands	22%
Pee Dee	26%
Low Country	27%

The credible county-specific data that we were able to calculate is depicted in the table below:

Figure 8: Uninsurance Rates by County

County	Region	% Uninsured
Aiken	Midlands	17.1%
Anderson	Upstate	16.4%
Berkeley	Low Country	15%
Charleston	Low Country	19%
Florence	Pee Dee	16.8%
Greenville	Upstate	14%
Horry	Pee Dee	30.9%
Lexington	Midlands	19.6%
Orangeburg	Midlands	13.3%
Pickens	Pickens	14.5%
Richland	Midlands	16.3%
Spartanburg	Upstate	20.7%
York	Upstate	24.1%

1.2.12: Duration of Uninsurance

Most individuals responding to the Household Survey had been uninsured for some time. When asked if the individuals had any health insurance in the past 12 months, 29% responded "yes" and 69% responded "no."[xvii] The largest percentage of respondents had been without insurance for over 12 months.

1.3: Population Groupings Important to South Carolina

Our research focused on the small employer or small group market in South Carolina. Seventy percent (70%) of the businesses in South Carolina have 50 employees or less. Approximately 73% of employers with 2-50 employees (or 5.6% of all businesses) and 26.7% of employers with 51-100 employees (or 2% of all businesses) do not offer insurance.[xviii] Approximately 20% of all businesses with less than 100 employees in South Carolina do not offer insurance coverage; therefore, small businesses were the focus of both qualitative and quantitative research activities. Accordingly, the population that appears to be in most need of a policy change is the working uninsured.

While the working poor have obvious issues with the affordability of insurance, it is clear from the data that several middle class professions also indicate that they are uninsured due to the cost of health insurance. One particular group worthy of

more attention is the medical and/or professional group. Depicted below is a breakdown of the data by Employer group size.

Figures 9 and 10 show the percentage of all South Carolina companies that do not offer coverage by group size:

Figure 9: Companies that Do Not Offer Insurance By Group Size

Less than 10 employees	58%
11 – 20 employees	39%
21 – 50 employees	8%
51 – 100 employees	8%

Figure 10: Percentage of South Carolina Companies that Do Not Offer Coverage by Group Size

One surprising result of our research was the number of uninsured medical and professional employees.

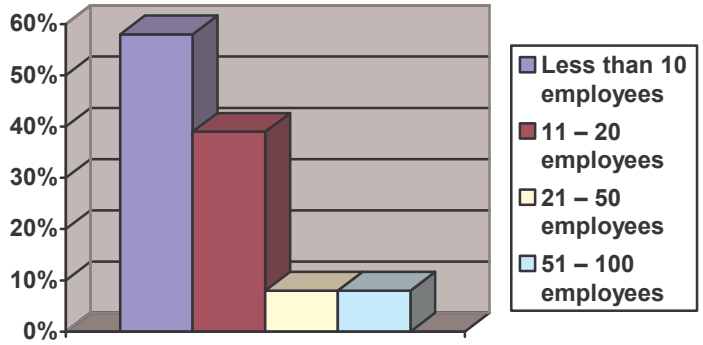


Figure 11: South Carolina Medical and Professional Employees by Group Size:

	Professional	Medical
Less than 10 employees	47%	18%
11 – 20 employees	6%	4%
21 – 50 employees	3%	10%
51 – 100 employees	44%	68%

The percentage of medical and business professionals who indicate that "affordability" is the reason they are not insured is 48%. This group believes employer-sponsored insurance is important to retaining employees, but are of the

opinion that the options available are not affordable. This is particularly true for businesses of less than 20 employees. On the other hand, retail trade (83%) and hotel, motel, restaurant or entertainment businesses (56%), had high percentages of uninsured but responded that they did not think health insurance was an issue in attracting new employees. These statistics provided an opportunity to focus on the types of businesses that most need, and want, affordable health insurance. These statistics may also provide us with a strong advocate for change in the small group market.

Figure 12: Negative impact of not having employer-sponsored insurance in attracting employees:

	No Impact	Impact
Medical	46%	54%
Professional	49%	51%

Members of the medical community believe that not offering health insurance benefits is an impediment to attracting and retaining employees. Based upon the data results, the population grouping of most importance to South Carolina is the working uninsured.

1.4: Affordable Healthcare Coverage

Affordability is the most cited reason an individual lacks health insurance coverage. However, the answer to what constitutes affordable coverage depends on whom you ask. Answers vary depending on whether you ask a large employer, small employer, employee, young person, older person, low-income or middle-income individual. In 2000, the Medical Expenditure Panel Survey (MEPS) reported that the average health insurance premium in the private sector was $2,655 for single coverage and $6,772 for family coverage.[xix]

The Household Survey data shows that South Carolinians making $30,000 with professional and/or medical jobs still find health insurance unaffordable. Many people look at the cost of health insurance the same way they look at all of their monthly expenses. In other words, they prioritize what has to get paid (mortgage, food, child care) and whatever is left goes towards paying the rest of the bills. Many times health insurance is not considered a priority when food and shelter take up most of the monthly family income. Even the 43.5% percent of uninsured South Carolinians that have a gross household income between $20,000 and $50,000 are uninsured because they cannot afford health insurance. The key is not everyone can pay the same amount, which is typically how group insurance premiums are calculated.

Employee Focus Group participants' responses indicated that they might be able to pay between $25 and $175 per month for health insurance, although some

participants could not pay more than $10 per month. The response to this question during the Key Informant Interviews was that employees should pay 20% to 25% of the total premium cost as an incentive to make them more accountable for healthcare utilization. Insurance agents suggested that employees should pay 2% to 3% of their income on health insurance, but never more than 5%. Some employers thought that $1 per hour of wages, or 10% of the after-tax income would be an affordable premium for their employees.

Small employers struggle to provide health insurance as part of their benefit package in an effort to maintain and attract a strong workforce; however the administrative costs of providing coverage can be burdensome. Employers responding to the small employer survey that do not currently offer insurance were asked how much they would be able to contribute toward employee health insurance benefits. The answers varied as illustrated in the table below.

Figure 13: Amount Small Employers Would Contribute to Employee Health Insurance Benefits

Amount Per Employee Per Month	Percentage
Less than $50	33.34
$50	17
$100	18
$150	2.9
$200	2.41
$250	.96

Several respondents to the Utilization Survey wrote that they had incurred huge medical bills while they were uninsured. In addition, some people encountered providers who would not continue care if outstanding bills remained unpaid.

1.5: Non-Participation in Public Programs

The responses of Employee Focus Group participants suggest several reasons why people do not participate in public programs. Those responding cited the following:

- lack of access/transportation;
- the cost of benefits not covered by public programs (prescription drugs);
- the treatment received from physicians when they do not get paid promptly for services; and
- the poor condition of some public medical facilities.

During the meetings with Key Informants, this question elicited responses such as:

- "there is a stigma attached to public programs;"
- "eligible individuals do not know they are qualified for public programs;"
- "bureaucracy and paperwork is cumbersome;" and
- "public programs are considered sub-standard care."

It is interesting to note the difference in perspectives of people who are eligible for public assistance and Key Informants. Key Informants attribute the lack of participation to lack of awareness and the stigma associated with public programs. However, from the perspective of the uninsured, the quality and adequacy of care of public programs deter enrollment.

1.6: Disenrollment from Public Programs

Disenrollment appears to be based on changes in the employee's personal circumstances. Employee Focus Group members responded that they became ineligible due to changes in work status or a pre-existing condition and were unable to re-enroll due to a loss of eligibility. In addition, Key Informants believed that enrollees were discouraged from re-applying.

1.7: Non-Participation in Employer Sponsored Coverage

Respondents to the Employer Survey who offered health insurance were asked why employees most commonly declined coverage. Employers responded that although eligible, most uninsured chose not to participate in their employer's insurance plan due to cost. This includes the cost to employees and their dependents, which typically are not subsidized by the employer. Others do not participate in employer-sponsored plans because they have coverage through a spouse's employer. Some employees indicated that they did not feel a need for health insurance; health insurance was unnecessary. The reasons cited to support this conclusion included "young and healthy" and "the government will take care of me if I get sick." The Household Survey also confirmed that cost was a factor. Most employees cited the cost of the insurance as the reason they did not enroll in their employer's plan.

Key Informants were also asked why people did not have health insurance. In addition to the aforementioned responses, Key Informants stated: "employees would rather have a raise than healthcare coverage;" "the health coverage offered is not adequate;" and "lack of education regarding high debt for unpaid healthcare services."

1.8: Employer's Role in Providing Health Insurance

Employees in the Focus Groups expected affordable health insurance to be available through their employer, but felt that what was provided was either too expensive and/or had inadequate benefits. Many spoke of the need for government intervention and posed suggestions such as a basic coverage plan, sliding scale premiums based on income, and small employer associations created for the purpose of purchasing insurance.

State law already requires insurers to offer a "basic" and "standard" health plan to all small employers. Following the guaranteed issue provisions of HIPAA, many insurers stopped marketing these plans because all plans were guaranteed issue. However, these two plans are still mandated by law. Most employers were not aware of this requirement.

The Key Informants interviewed believed that health insurance was necessary to help retain and recruit good employees. They also believed that many employers feel a degree of responsibility to their employees and families for providing access to health insurance. They point out that employers experiencing rising health insurance costs, high turnover, and low profits may be forced to make a decision not to provide health insurance.

1.9: Availability of Subsidies, Tax Credits or Other Incentives

Based on responses in the Focus Groups and with Key Informants, subsidies and tax credits are helpful, but have not been enough to influence individuals to make a change. Other suggestions included:

- Imposing a mandatory requirement that employers contribute 65% towards health insurance premiums;
- Mandating that insurers provide a basic benefit plan with "reasonable" out-of-pocket costs;
- Developing an incentive for doctors who work with government programs and cooperative outreach programs (e.g., higher reimbursement);
- Providing an incentive for insureds to manage personal utilization and healthy habits throughout the year;
- Requiring government oversight of provider and insurance costs; and
- Determining individual premium contribution based on wages.

1.10 Barriers Other than Affordability

Focus group participants were asked why so many South Carolinians are uninsured. Many cited the cost of health insurance and associated out-of-pocket expenses as factors. Other barriers suggested in sessions with Focus Groups and with Key Informants include:

- no coverage available for illegal immigrants;
- lack of transportation;
- part-time and seasonal employment;
- lay-offs;
- pre-existing condition exclusions;
- lack of education regarding appropriate use of available healthcare facilities and coverage options; and
- enrollment/re-enrollment is not an easy process.

Others are not eligible for health insurance because of extended waiting periods and/or moving frequently from job to job. Employers cited cost as the primary reason they did not have coverage, but offered other concerns as well. About 11.41% "did not work enough hours"; 31.87% "had not worked long enough" and 6.04% reported that the "benefit package did not meet their needs." Some employers indicated that the majority of their employees did not want insurance because they already had coverage (17.21%); 1.92% indicated that their employees preferred higher wages; and 1.43% did not want to deal with the administrative hassle.

1.11: The Uninsured and Their Medical Needs

When asked how the uninsured are getting their medical needs met, the Focus Group participants stated that many uninsured used the emergency room and free clinics. Others went without healthcare services. The Utilization Survey was designed to collect demographic data on the uninsured as well as those persons who frequented the emergency rooms for their primary medical care needs. Through a supplemental grant, we were able to determine the annual cost of care per uninsured--$2,000. It is estimated that 112 South Carolinians receive medical services for which they cannot pay.[xx]

1.12: Features of an Adequate Bare-bones Benefit Package

Responses to the question of what are the features of an *adequate*, bare-bones benefit plan varied depending on the respondent. A Focus Group employee participant stated that healthcare should provide everything that is needed to make a person well enough to work. Some suggested that a bare-bones plan should include prescription drugs, wellness, emergency room and hospitalization coverages. Others indicated that mental healthcare, cosmetic surgery, eye care and dental were not necessary. Finally, some people thought that only catastrophic care should be considered as a bare-bones benefit plan.

1.13: Definition of Underinsured

"Underinsured" was defined generally as having coverage that had high out-of-pocket costs that the individual could not afford to pay. Others defined

underinsured similarly. Interestingly, there were some who defined underinsured as having only one family member covered under an insurance plan.

SUMMARY

The majority of the uninsured in South Carolina are employees 19 to 64 years of age who are self-employed or and work for small businesses. The rates of uninsurance are highest in the retail, tourism, hotel and motel and entertainment industries. Both employers and employees believe employers should have a role in providing health insurance coverage, but cite cost as the primary reason they do not offer or purchase health insurance coverage. Based upon the data collected, the working uninsured is the population grouping of most significance to this state. All analyses conducted the project confirm that cost is the greatest impediment to purchasing insurance coverage. Both the insured and the underinsured cite cost as the primary reason they lacked insurance coverage.

The data indicates that the majority of the uninsured would be willing to pay $50-$100 per month for a plan that provides basic but affordable health insurance coverage. However, there were different perceptions as to what constituted adequate or affordable coverage. Many survey and focus group respondents believed that government should be involved in controlling the escalating cost of insurance and making health insurance affordable. Others did not believe that government should provide health insurance coverage. This was the primary reason they did not participate in public programs.

The research data supports the policy options recommended by the HIPAC. Because most of the uninsured in South Carolina work for small businesses, the Medicaid Expansion option was designed to expand coverage to small employers. This option proposes a subsidy for families at or below 150% of the FPL to address affordability issues. Additionally, the legislative proposal allowing all community health centers to collect prepayment fees will enable these programs to expand and provide healthcare access to individuals who do not qualify for employment-based coverage. The program could design services to address the needs of the population within that community.

SECTION 2

EMPLOYER-BASED COVERAGE

Most private health insurance in the United States, and South Carolina, is employment-based. Because employers play a significant role in the provision of health insurance, an understanding of health insurance benefits from the employer's viewpoint was critical to developing options to expand health insurance coverage. Most South Carolinians work for small businesses. Therefore, South Carolina's grant focused on expanding health insurance coverage within the small group health insurance market. These results are based on analysis of the data on the uninsured drawn from the Employer Survey.

The Employer Survey was sent to 2,499 private businesses in the state with 100 employees or less. The sample was intended to be broadly representative of private businesses in South Carolina. The survey provides information on the size, industry sector, average employee income and geographic location of the business. For employers that offer coverage, the contribution rate per employee and participation rates were also measured.

2.1: Comparison of Characteristics of Firms that Do/Do Not Offer Coverage:

Employers that offer health insurance differ in size, industry and geographic location. What follows is a summary of the quantitative data from the Employer Survey as reflected in Tables 55-64 of Appendix I.

2.1.1: Employer size (including self-employed)

The survey did not consider firms of all sizes. However, among the firms surveyed, there was great disparity in the likelihood of offering coverage based on the number of people employed by the firm. An analysis of the data from the Small Employer survey reveals that the majority of South Carolina's uninsured work for employers who do not offer health insurance coverage. Forty-seven percent (47%) of employers with 1 to 50 employees report that they do not offer health insurance, compared with 8.67% of employers with 51 – 100 employees. Seventy-three percent (73%) of uninsured businesses have 0-50 employees compared to 21% of insured businesses.

The size of the employer also impacted the employer's contribution. The smaller the employer, the less likely the employer would contribute to the employee's premium. Most insurers require a minimum of 50% employee contribution. Almost all employers require that the employee pay 100% of the dependent insurance coverage cost. As previously discussed, this data supports the need for affordable small group health insurance options.

2.1.2: Industry sector

The level of uninsurance varies by industry sector. Approximately 15% (14.74%) of the businesses surveyed who did not offer insurance were in construction (compared to 11.32% construction businesses that did offer coverage); 13.16% in hotel/motel or entertaining did not offer coverage (compared to 9.30% hotel/motel businesses that offered coverage); 19.47% in professional and related services did not offer coverage (compared to 8.89% professional and related businesses that provided coverage) ; and 11.58% in retail trade did not offer coverage (compared to 11.32% retail trade businesses that provided coverage). By comparison, 16.44% of manufacturing companies were insured compared to 5.26% uninsured. The data revealed a lack of health insurance options for part-time and seasonal employees. Many employers do not offer insurance coverage to this category of employee. The uninsured data by region illustrates this. In the Low Country and Pee Dee regions, both of which heavily rely on tourism, the data indicates that there are more uninsured in these regions and there are fewer employers offering coverage to their employees. Additionally, some medical practices are not offering insurance coverage. These medical professionals also cite cost as the reason coverage is not offered.

2.1.3: Employee income brackets

Generally, individuals in lower income brackets are more likely to be uninsured. From the Household Survey, it appears that most uninsured South Carolinians have an average salary for full-time employees between $10,000 and $50,000. Twelve percent (12%) stated average salaries were between $10,000 and $15,000, 16% stated average salaries were between $15,000 and $25,000, 19% stated average salaries were between $25,000 and $35,000, and 16% stated average salaries were between $35,000 and $50,000. Four percent (4%) of uninsured South Carolinians have an average salary of less than $10,000 and 22% make more than $50,000 annually. More and more, the lack of affordable health insurance is becoming as much a middle-income problem as it is a low-income problem.

Interestingly, employers responding to the Employer Survey report that less than 5.5% of the uninsured employees have salaries below $10,000, 44% have salaries between $10,000-$20,000 and 47% have salaries between $20,001-$50,000. By comparison, employers reported the following as average salaries for the insured: less than 1% earn salaries below $10,000; 16% of insured employees earn between $10,001-$20,000; and 79% earn between $20,001 and $50,000.

2.1.4: Percentage of Part-time and Seasonal Workers

On average, 27% of the uninsured are part-time or seasonal employees.[xxi] Most of these employees are working in the retail and tourism industries. The South Carolina health insurance laws do not require insurers to cover employees working less than 30 hours per week, so often these employees are not eligible for group health insurance coverage through their employer.

2.1.5: Geographic location

The household and employer surveys did not cover every county of the state, and it is therefore not possible to determine the percentage of uninsured for each county. However, the larger counties have been analyzed. The data is available in Section 1.2, "Geographic Location." The uninsured rate in Charleston County, in the Low Country region, approximates 19% uninsured. This equals the rate of uninsurance for the state. Horry County, in the Pee Dee region, is a high tourism area and has 31% uninsured residents. Lexington and Richland counties were 19.6% and 16.3% uninsured, respectively. These two counties represent the Midlands region. Greenville County and Spartanburg County are both in the Upstate region but ranked significantly different, with 14% uninsured in Greenville County and 21% uninsured in Spartanburg County. Greenville County has a much higher percentage of large businesses than Spartanburg County and the rest of the state.

2.1.6: Effect on ability to attract employees

Fifty-seven percent (57%) of the employers who do not offer insurance stated that it did not have an effect on employee retention and recruitment.[xxii] This is not consistent with national findings that employees rank health insurance as the number one employer benefit regardless of the type of industry in which they work. Most of the employers who responded that offering health insurance had no impact on employee retention or recruitment were most likely in tourism related industries.

2.1.7: Employers who do offer coverage

2.1.7.1: ***Cost of Policies***: In 2000, the average cost for a policy nationally was $2,655 for an individual and $6,772 for a family.[xxiii] This data was not available for the State of South Carolina. The survey results indicated that cost is the primary factor for employers when considering health insurance. South Carolina law requires that insurers offer a basic and standard insurance plan. These plans do not appear to be very popular

among consumers. They point out that premiums are increasing by double-digits annually, and the amount of annual premium increases may be higher for small employers. Last year (2003) was cited as the third straight year of double-digit increases, and 2004 has not been any better.[xxiv] To reduce costs, employers are considering dropping coverage, reducing benefits, reducing their contribution to employee premium, and moving to health savings accounts. However, each of these options impacts the employee's ability to pay his portion of the premium and his total out-of-pocket costs.

2.1.7.2:*Level of contribution*: More than 60% of the small businesses offering coverage to employees pay 25% or less toward monthly insurance premiums. Thirty percent (30%) pay nothing toward their premium, 34% pay between 1% and 25%, and 28% pay between 26% and 50%.[xxv]

The data results indicate that low and middle-income employees elect not to participate in employer-sponsored insurance plans when they are required to pay more for premium, deductibles, coinsurance and co-payments. Employers must meet minimum participation requirements in order to be eligible for group coverage, and some employers are finding that they are not eligible for group health insurance because employees who cannot afford coverage will not participate. If employees have to drop insurance coverage due to cost, this decision also impacts the employees who are willing to pay the premiums when the employer goes below the required participation level. This is particularly difficult for smaller employers who have stricter participation requirements.

2.1.7.3:*Percentage of Employees Offered Coverage Who Participate*: Businesses that offer insurance coverage report substantial rates of nonparticipation. Participation levels are low by comparison. The employers surveyed indicated that *some* employees (63%) were offered coverage but elected not to participate. By comparison, other employers reported that *none* (21%) of their eligible employees chose not to participate in group coverage when offered.[xxvi] The data is clear that "cost" is almost always the reason for not electing health insurance.

Clearly, a subsidized premium program for employees in low wage positions may help small employers to offer coverage and increase employee participation. Another consideration is to have two health insurance plans from which to choose, and have each employee pick the one that best suits his situation.[xxvii]

2.2: Influences and Primary Reasons for Employers Not Offering Coverage

Influences and primary reasons for employers not offering coverage include:.

Cost: The number one factor influencing the employer's decision not to offer group health insurance is cost. Small employers are very sensitive to the cost of employee benefits because their profit margin is much smaller than large businesses.

In addition, the administrative burden of a group health insurance plan can be significant. Small businesses believe that there is a lack of competition in the small group health insurance market, which influences the average cost of coverage. In South Carolina, insurance companies have the ability to price within a range of the index or actuarial base rate, and this can cause problems for employers with one or more high claims. However, this rating system has helped keep healthy groups insured at reasonable rates.

Status: Although the Employer Survey did not inquire into the issue of employment status, responses during the focus group sessions and to the household survey indicated that employment status may be a factor. Employers generally choose to offer health insurance coverage to full-time employees, not part-time, temporary or seasonal. Also employees may have a waiting period or a certain length of time they have to be employed in order to qualify for coverage.

As a consequence, some employers have had to offer reduced benefit plans to keep the employer and employee costs in line with the previous year's premiums. Some small employers expressed a concern about offering health insurance benefits because one person/claim has the ability to dictate the rates for the entire group. Many small employers are looking at health savings accounts as an alternative and as a way to control costs.

2.3: Factors that Influence the Employer's Decision About Health Insurance and Benefits Package

Cost influences the employer's decision to offer health insurance as well as the plan's benefit design. The benefits package offered will be based upon price. Employers try to keep the premiums at a level that both they and their employees can afford. Other factors considered were the insurer's participation requirements, contribution rules and the number of employees who have coverage under a spouse's plan. Employers, when trying to reduce the premiums, also look toward high deductible plans that place more of the cost burden on the employee.

Another common issue is continuity of care for employees, particularly those who have chronic conditions. Although it is normal for small employers to shop for better rates/benefits each year, moving coverage to a different insurance company every year can disrupt care and result in more out-of-pocket expenses for employees.

2.4: Response to an Economic Downturn and Increased Costs

The economic downturn and the rapidly rising costs of healthcare and insurance premiums continue to force employers to reconsider health insurance as an employee benefit. In order to keep insurance premiums down or at least at the same level annually, employers are reducing the benefits offered. Usually, this is in the form of higher co-payments, deductibles, and reducing maximum annual and lifetime limits on certain benefits. Employees are being required to pay a larger percentage of the total cost of their health insurance. Some employers are considering moving towards consumer-driven health plans (health/medical savings accounts) to encourage employees to be more responsible for personal utilization and provider choices. The outcome for low-wage employees may be a reduction in primary and wellness care, since these are examples of services for which the employee would pay. Other employers are offering money to employees that would go towards the employee's cost of health insurance or medical bills. Hiring part-time workers to replace full-time workers is another trend that is occurring in South Carolina. Increases in employee co-payments, deductibles and coinsurance reduce benefits in exchange for lower premiums.

2.5: Crowd-Out

Crowd-out occurs when new public programs or expansions of existing programs designed to extend coverage to the uninsured prompt some privately insured individuals to drop their individual insurance coverage and enroll in the public program. It may also occur when expanded public programs act as an incentive for employers to contribute fewer dollars to the employees' coverage or the employee drops coverage to enroll in the public program.

The most vulnerable groups are small employers with 0 to 14 employees.[xxviii] This does not appear to be a market that most insurers writing small group coverage are interested in pursuing. Therefore, any programs targeted towards this group will "crowd-out" insurers, but should not impact the private insurance market significantly.

2.6: Employer Influences to Offer Coverage

2.6.1: Expansion/development of purchasing alliances

South Carolina insurance law allows small businesses to band together for the purpose of purchasing health insurance. However, there has been very little movement towards creating these alliances. It is believed that the main reason for the lack of interest is that there is not an entity that is willing to develop, market and manage a small business purchasing alliance. However, benefits of an alliance would be pooled claims, possible reduced premiums, and lower administrative costs. This is the

number one health insurance reform supported by the National Federation of Independent Businesses. The South Carolina Small Business Chamber of Commerce has introduced legislation to allow small employers to buy into a pool similar to the state health plan that would be administered by the Office of Insurance Services. There is some governmental support for purchasing pools, however.

2.6.2: Individual or employer subsidies

Employee tax incentives are helpful, but would have to be significant to encourage employees to purchase health coverage. Employer tax credits may not be useful if they have no income against which to apply the credit. To be most effective, the credit would have to be available before the payment was due, or go directly to the insurance company or employer in lieu of monthly premium payments.

2.6.3: Additional Tax Incentives

During the Focus Groups, additional suggestions were made, including a rebate incentive for low utilizers, and a tax incentive for insurance companies who assist the state in providing high quality insurance at affordable costs. Another suggestion was to financially motivate insureds that manage their weight, receive annual examinations, take medications as prescribed, and basically follow their doctor's orders. This was deemed to be a great incentive for people to be more responsible for their own health and welfare.

2.7: Other Employer Motivators

Focus Group participants mentioned that more federal and state involvement is needed to develop a healthy workforce. The residents and employers of Greenville, South Carolina, under the leadership of a retired physician and nutritionist, have created a program called *Healthy Greenville*. This program aims to work with children to start vegetable gardens, local chefs to create healthy meals and teach healthy cooking, and employers to get employees physically fit. Charleston, South Carolina is considering adopting a similar program.

It was also suggested that a basic benefit plan be mandated.[xxix] However, the state already mandates that all small group insurers provide a basic and standard benefit plan to small employers. While insurers have not heavily marketed these two particular plans, the small group market is requesting similar options that would reduce insurance premiums. Again, the problem is not access to health insurance, but affordability.

Participants also suggested simplifying claims payment and other administrative procedures, limiting prescription drug advertising, limiting profits to insurance companies, and reducing liability for medical providers as ways to reduce health insurance premium costs. Web-based fitness and wellness programs, nurse help lines, and employee education are other alternatives that may motivate employers to offer coverage.

SUMMARY

The results from the Employer Survey were supposed to enhance the policymaker's understanding of issues confronting small business and its employees. The data revealed that most employers would like to offer health insurance coverage as a benefit, but many do not because of the cost. To continue to offer health insurance coverage, many employers are shifting more of the cost to their employees. Some employers require employees to pay as much as 50% of the cost. For this reason, many employees do not enroll in the employer's health insurance plan. They cannot afford the co-pays or the cost of dependent coverage. Interestingly, the majority of employers who do not offer insurance coverage did not think it had any impact upon their business' ability to recruit or retain employees. Some employers are also considering health savings accounts as an alternative.

The responses of both employers and employees as to what needs to be done to expand health insurance coverage revealed that many were not aware of existing state laws. For example, some suggested that insurers offer a bare-bones policy when state law already requires insurers to offer such a product. Many insurers do not widely market this product because consumers typically are not interested in the limited nature of the benefits. Concomitantly, others suggested that small employers be allowed to form purchasing alliances. South Carolina law permits the formation of purchasing cooperatives. Opinions differed as to what constituted a bare-bones policy or what an adequate insurance policy should cover.

There was no difference of opinion regarding the impact of cost on health insurance coverage. Because employers and employees cite cost as the reason they do not offer or purchase health insurance, the HIPAC focused on the cost of a health insurance product when designing the Medicaid expansion option. The benefit structure for the plan was based on the benefit structure for the State Employees Plan. Its basic benefit structure was deemed to be adequate. However, in determining the cost for the proposed product, the HIPAC considered the responses of employers and employees. The proposed cost would be at a level both the employer and employee could afford.

SECTION 3

THE HEALTHCARE MARKETPLACE

3.1: Adequacy of Existing Insurance Products

Evaluating adequacy of coverage is subjective because adequacy is defined in a variety of ways. Some define adequacy as the availability and affordability of insurance coverage while others believe that insurance is not adequate if it does not meet the needs of the individual. For example, some products may be adequate for some segments of the population, but these same products may be inadequate for others due to cost.

While measuring the adequacy of insurance products was not a specific component of our research activities, the adequacy of insurance coverage was the subject of frequent discussion by key informants, the HIPAC members and focus group participants. There is some disagreement about whether the existing marketplace offers adequate coverage.

Insurers writing business in South Carolina provide a wide array of group and individual products, at different benefit and price levels. Some of these insurers specialize in the 2 to 10 employee market, some are only small group (2 to 50 employees), and some insure all size cases. All groups are protected by HIPAA portability and renewability protections.

Individual products are also available but underwriting is allowed and not everyone qualifies. Health conditions can be excluded from an individual benefit plan and/or the premium rate increased for the condition. There are products available for individuals and the self-employed, but not if you are unhealthy. Unhealthy individuals who have been denied coverage may be eligible for the SCHIP. However, these plans tend to be expensive and may not be affordable for most low to middle-income citizens. In addition, pre-existing condition limitations may apply.

Affordable options for low and middle-income employees are limited. In the past, reduced benefit plans have been available from insurers, but have not sold well against more generous benefit plans. Employment-based health insurance decisions are almost always up to the employer and not the employees. Given a choice, the employer will pick the plan that best fits his business' needs.

Some health insurance products are available, but many believe that these products are not adequate because they do not meet the needs of the consumer. Some believe that the lack of competition in the small group market is affecting the adequacy of the products. There are currently 23 licensed insurers that write in the small group health insurance market in South Carolina.[xxx] One of these

insurers has given notice of its withdrawal from the small group market as of January 1, 2005. Moreover, some insurers are licensed, but do not currently write new business in the state. As a result, one insurer dominates both the small group and individual market. Some believe that these market conditions have created a non-competitive rating environment for small employers and the self-employed.

Conversely, there are others who believe that the increase in the cost of health insurance is due to overly generous insurance benefits. They propose that limited or reduced benefit plan options are the only way to reduce insurance premium costs.

South Carolina law already mandates a Basic and Standard Plan, but these plans are not widely marketed by insurers. Anecdotally, insurers indicate that these plans are not widely marketed because consumers do not purchase them. They are not popular because of the limited nature of the benefits they offer. Historically, consumers have not considered the benefits adequate.

Health/Medical Savings Accounts (HSAs/MSAs) are frequently offered as an alternative because they are considered more affordable. HSAs/MSAs also require an educated consumer to make the most of the money in the savings account and coordinate it with their high deductible plan. Most low-income uninsured may not be helped by HSAs if they cannot afford the monthly premium for the high deductible policy or the contribution to the medical savings account.

Congress enacted legislation in 2003 to allow people to establish health savings accounts to work with qualifying high deductible health insurance to assist with the financing of healthcare services.[xxxi] Employers could start making contributions to those accounts in 2004. HSAs must be established in conjunction with high deductible health plans (e.g., plans with $1,000 or more) and annual out-of-pocket expenses that do not exceed $5,000.[xxxii]

It is unclear whether HSAs will expand insurance coverage. Proponents of HSAs believe that consumers will make more prudent choices regarding healthcare when their own money is at stake.[xxxiii] Opponents believe that these plans will do little more than shift more of the healthcare costs to employees and providers.[xxxiv]

3.2: Variation in Benefits

Although many provisions required in group plans also apply to individual plans, coverage options may differ in the small group and individual markets. Individual plans have higher deductibles and co-insurance requirements. Some benefits considered standard for group plans are not standard in individual plans. Moreover, coverage for pre-existing conditions may be limited in group plans (up to 12 months), but may be excluded entirely in individual insurance plans. Group insurance provides credit for creditable coverage, but individual plans do not. Small group plans tend to have higher premiums and higher administrative costs.

There is a reinsurance pool available to insurers writing small group coverage that can help insurers with unhealthy individuals. There are also some fully-insured association plans that are available to South Carolinians.

Large groups (generally 100 to 1,000 employees), insured and self-insured, typically have much more flexibility in plan design. Because the employee risk pool is larger, costs tend to be lower. Self-insured groups can define their benefits, are not subject to state mandates or state insurance laws, and have the final decision on all claim payment issues.

3.3: Prevalence of Self-Insured Firms

Self-insured firms are not as prevalent in South Carolina as they may be in other states. Small businesses comprise the vast majority of South Carolina companies, and cannot afford to self-insure their own risk. Most self-insured plans are not subject to state regulation because of Employee Retirement Income Services Act (ERISA) requirements. The largest self-insured plan is the State Health Plan that covers approximately 60% of South Carolina employees or approximately 340,000 employees. Several years ago, the State Health Plan changed the HMO plan options from fully-insured to self-insured.

3.4: Impact of State Purchasing

The State of South Carolina plays a significant role in the market as a purchaser of health insurance coverage for state employees. It is one of the largest purchasers of healthcare services. The State Health Plan and Medicaid negotiate independently with providers and are able to set low reimbursement rates. Inevitably, there is cost shifting by the providers to insurers and self-paid patients. In 2004, Medicaid began considering the addition of medical management and utilization review to help control costs.

3.5: Impact of Current Market Trends and Regulatory Environment on Universal Coverage

Current marketplace trends include double-digit rate increases and benefit plan reductions. There is currently a moratorium on healthcare mandates and there has not been any significant health insurance legislation requiring mandates in several years. Health/Medical Savings Accounts, and other consumer-driven health plans, have increased in popularity as the federal regulations make them more user-friendly.

None of South Carolina's policy recommendations would result in universal coverage. Substantial legislative changes would have to be made in order to mandate universal insurance coverage. This is unlikely given that the state has had a moratorium on health insurance mandates over the past few years. Mandates are viewed as a potential health insurance cost driver.

3.6: Universal Coverage and the Financial Status of Health Plans and Providers

The HIPAC is recommending three policy options that will be developed and implemented simultaneously. The net effect of these policy changes will not ensure universal coverage. However, it may decrease the number of people without any access to healthcare services. The education policy option, which includes the website, will assist the uninsured in locating coverage. It should also help consumers make appropriate and cost-effective decisions when utilizing the healthcare system.

Possible effects of universal coverage include a decrease in cost shifting and an improvement of the financial status of providers due to a reduction in uncompensated care. However, the cost of a universal coverage option makes it an unlikely option for the state.

3.7: Safety Net Providers

The HIPAC is made up of various safety net providers, all of which are taking part in the development of policy options for the uninsured. Their input has been invaluable. While the primary goal of our research was to expand health insurance coverage, one of our primary considerations was the financial viability and continued growth of our safety net providers. The policy recommendation that proposes allowing non-profit community health centers to collect prepayment fees will provide these centers with another funding mechanism.

3.8: Utilization Changes Due to Universal Coverage

If there was universal coverage, presumably there could be a decrease in inappropriate use of the emergency room (i.e., using the emergency room for non-emergency, primary care services). However, there may also be an increase in high dollar medical services, such as surgery, diagnostics and prescription drugs, as people typically defer these services when they are uninsured. These costs would eventually plateau and then increase as this population ages.

3.9: Experience of Other States

The HIPAC and the SPG staff spent a significant amount of time researching the experiences of other states. The HIPAC reviewed other HRSA SPG projects and initiatives to determine what policy initiatives should be considered or discarded. The HIPAC considered the expansion of public coverage; public/private partnerships; incentives for employers to offer coverage and regulatory issues.

A number of articles containing incentives for employers and employees were reviewed. It was determined that the incentives would be ineffectual because they could not be set high enough to effect change. The HIPAC was particularly

interested in the Arkansas Minimum Benefit Plan,[xxxv] the One-Third Share Plan in Illinois[xxxvi], and the South Carolina Health Access Plan[xxxvii], a past Medicaid expansion program for small businesses. Each was thoroughly reviewed to determine whether it was a viable option for South Carolina. Most of the options pursued by other states appeared impractical for South Carolina at this time.

SUMMARY

Self-insured firms are not as prevalent in South Carolina as they may be in other states. Thus, insurers provide the vast majority of products to the group and individual market. Adequacy is defined in a variety of ways but most definitions include some basic benefit structure and limit the out-of-pocket expenditure required from the employee. Insurance products are more expensive for small employers because of the size of their risk pool. Additionally, the number of insurers writing in the small group health insurance market is limited. For these reasons, many employers do not consider existing insurance products to be adequate. To address the cost of the product, employers are either shifting costs or reducing benefits. Neither appears to be satisfactorily meeting the needs of employees. As a result, employees are electing not to participate in employer-sponsored benefit plans either because of the increased cost or because the reduced or limited benefit plan does not provide the necessary coverage. The options recommended by the HIPAC may expand health insurance, but the net effect will not provide universal coverage.

SECTION 4

OPTIONS AND PROGRESS IN EXPANDING COVERAGE

4.1: Options Considered for Expanding Coverage in South Carolina

The HIPAC considered many policy options before reaching consensus on three final policy recommendations. There were divergent views among members of the HIPAC on the nature of the problems facing the uninsured. Some individuals were more concerned with the poor; thus, their recommendations were based on expanding eligibility for Medicaid, State Children's Health Insurance Program (S-CHIP) and other public programs. Small business representatives were interested in creating pools or associations and making changes to the small employer health insurance laws. Universal coverage options were discussed and were supported by physicians and consumer advocates alike. Public policy experts had researched and proposed legislation allowing small businesses to use the State Health Plan on a self-funded basis.

There were issues where there was immediate consensus. The SPG staff and the HIPAC agreed that the number of uninsured in our State was increasing, the cost of private health insurance was not affordable to many small employers, and the recession was making it increasingly difficult for Medicaid to cover the increased growth of Medicaid-eligible recipients. Members of HIPAC also agreed that the policy recommendations should be based on the data, analysis, research and the current fiscal conditions in South Carolina

The policy options researched and considered over the past two years include:

- Creating a South Carolina version of the Arkansas Medicaid expansion program, currently under review by the federal government, for working adults under 150% of the Federal Poverty Level;
- Considering community programs similar to the Illinois Third-Share Plans;
- Enhancing the S-CHIP eligibility from 150% of the federal poverty level to 200%;
- Establishing a physician best practice manual that requires physicians to treat all patients, regardless of their ability to pay, with the same protocol;
- Requiring insurers to provide a minimum benefit plan to small employers;
- Creating a no-mandate benefit plan for small employers;
- Allowing non-profit community healthcare programs to collect a pre-payment fee from patients that are able to pay;
- Creating educational programs for employers, agents, brokers, citizens, and children (school-based program) to teach people what is available in their community, county, state and how to access that care in the most appropriate and affordable way;

- Creating a small employer self-funded pool through the State Budget and Control Board;
- Reviewing the small employer health insurance statutes for possible changes that would create opportunities for uninsured small employers and employees; and
- Eliminating the medical benefits from workers' compensation plans.

For each of these potential options, the HIPAC considered the benefit to the consumer as well as the cost of implementation. This analysis made some of the options not feasible—the cost of implementation outweighed the projected benefit or implementation funds were not available. The final policy recommendations from the HIPAC are outlined below.

4.1.1: South Carolina's Options for Expanding Coverage

4.1.1.1: Option 1--The South Carolina Small Employer Health Plan Option

Since many uninsured are self-employed or work for small businesses, a program that would expand Medicaid coverage to the working poor should reduce the number of uninsured. The goal of this program is to provide a statewide small employer coverage option that will cover all of the employees in a group, subsidize the premium for covered individuals/families under 150% of the FPL, and not appear to be a public assistance program. The benefit plan is limited, but still covers the basic healthcare services used by the average South Carolinian (based on analysis of annual visits/services in the State Health Plan). Premiums will be kept at an affordable level for the employer and employee. The targeted population is the currently uninsured so this option should provide them with access to affordable healthcare. In addition, it will provide reimbursement for provider services that has not previously been available from this uninsured population. Provider payment rates and administrative costs should be less under Medicaid than that for private insurance.

Eligibility Criteria for the South Carolina Small Employer Health Plan Option

Employers are eligible if they have:

- 1 to 100 employees
- A South Carolina business license
- A physical address in South Carolina
- No previous group accident and health insurance coverage in the preceding 6 months
- Under consideration – average employee income by employer

An employee is eligible if he/she is:

- A South Carolina resident;
- Ineligible for Medicaid; and
- Employed an average of 25 hours per week

The benefit plan was designed to keep costs at $1,000 per year per employee/employer. Premiums will be subsidized for individuals and families under 150% of the FPL. A federal waiver will be required to allow matching funds to be used to pay two-thirds of the annual premium with federal funds. The benefit plan is based on average utilization of services by state employees covered by the State Health Plan (Year 2002/individuals under 65).

Proposed Benefit Design Summary

Proposed S.C. Base Benefit Plan (per year, per covered member):

- 1 hospitalization per year;
- Unlimited emergency room visits, when approved by a physician;
- 12 physician visits/ managed medical home required;
- 4 prescriptions per month
  - Mandatory generic drugs
  - Must be filled at 340B entities
  - Mail order available for maintenance drugs
- Well-child healthcare visits (EPSDT)
- Short-term therapy (PT/OT/ST) limited to 20 visits at 50% coinsurance.
- Mental Health covered as any other illness
- Diagnostic testing

Reinsurance will be required for this program. The data collected overwhelmingly supports this policy option. As previously stated, this option would be geared toward low-income workers and their dependents whose employers do not offer coverage. Approximately 150,000 South Carolinians would meet the criteria for this program if such an option were available.

Despite differences of opinion on the value of limited or less comprehensive benefit plans, it was determined that we needed to develop a benefit plan that was affordable. The plan we have proposed actually has better benefits in some areas than the average State Health Plan consumer may need annually. The benefit plan was priced based on the average employee salary, not just the few high-wage employees who could afford it. We included a subsidy for the very low-income employees, and eliminated waiting periods and pre-existing condition limitations. There were some members who did not agree with this recommendation because the providers would be in the Medicaid network and reimbursements would be based on the Medicaid reimbursement level.

No assumptions were made about possible adverse selection. Premiums would be equal to the actuarial cost of the program. The cost of the expansion would be fully funded through the premium contributions of small businesses and their employees.

The plan also does not cover all services. It was the consensus of the group that this is a reasonable starting point considering the budget issues in our state. In the future, if the economy changes for the better, the state can consider adding benefits and/or increasing provider reimbursement.

The development of this policy option, including the application of a Section 1115 waiver, has been referred to the South Carolina Department of Health and Human Services. This agency may have access to HRSA funding in 2005 to assist in the policy research and development process.

4.1.1.2: Option 2--Healthcare/Insurance Education

Premium rates have increased significantly in the past few years. Some estimate that premiums have increased by as much as 35%. An overall increase in the cost of health care is the principal cost driver, but it is not the only one. Medical inflation certainly plays a role, but health insurance costs are rising not only as a result of medical inflation and other factors,[xxxviii] but also as a result of our increased utilization of the system and rate of uninsurance. Americans are using healthcare services at higher rates than ever before. Nationally, our population is aging; consequently, the overall utilization of healthcare is on the rise. Employment-based coverage is diminishing as a result of increased insurance premium costs. Health status may also be a major factor in increased utilization.[xxxix]

Adverse selection may be a contributor also. Generally, young people do not purchase health insurance when they should because they consider themselves healthy and believe they do not need health insurance coverage. As a consequence, people generally tend to purchase insurance when they become unhealthy. Because the quality of care has improved

significantly in the last two decades, consumers have become more sensitive to the value of healthcare, and thus demand for healthcare services has increased. Some experts opine that more Americans are relying less on preventive behavior (balanced diet and exercise) to maintain health and more on healthcare services. As healthcare utilization and spending increase,[xl] so do health insurance premiums.

The rate of uninsurance also increases premiums. When the uninsured get sick and seek healthcare services through ER or other facilities for which they cannot pay, the cost of their care is passed on to others in the form of increased charges. Providers and doctors increase their fees to account for uncompensated care and then pass those fees along to insurers who in turn pass them on to insured consumers in the form of higher insurance premiums.

The collective opinion of key advocates, including insurers, agents, public program administrators and providers, was that there was a clear lack of knowledge about: 1) how to access the healthcare system; and 2) how to appropriately manage personal utilization of medical services. The number of South Carolinians who do not have health insurance and are not enrolled in public or community programs for which they are eligible supports this conclusion. Most do not know what programs exist and whether they are eligible. In addition, the number of uninsured who use the emergency room for all of their healthcare services continues to rise. Based upon anecdotal evidence, some providers estimate that one in three people in the Emergency Waiting Room has insurance. We all pay for this uncompensated care through cost shifting by providers to the insurers and through higher taxes. Educating consumers is the key to the success of any policy recommendation and, if done effectively, will reach more people than any other policy option recommended by the HIPAC.

The HIPAC focused on two goals for this policy option. The first was to develop programs that educate South Carolinians to be better informed healthcare consumers thereby impacting costs. The second was to create a user-friendly website for citizens and their advocates to find available public and private health coverage in order to decrease the number of uninsured. The SPG was used for data collection, research and analysis, and policy development. It could *not* be used for implementation. Outlined below are the educational programs supported by our research. It is our recommendation that continued funding is secured to support these educational programs.

Web Site – www.coveringtheuninsuredsc.org

The website, www.coveringtheuninsuredsc.org, was created to support the goals of this policy option. The website provides

information on access and eligibility to South Carolina's small employers, their employees and the community. When fully operational, the website will be interactive and will allow users to e-mail questions. Below is a description of the information available on the website:

HRSA SPG Information:
Purpose of grant
Data collection methodology and analysis
Policy options
Copy of final report
Link to Office of Research and Statistics for additional information on data

Uninsured in South Carolina:
Data Summary

Community Resources:
The Community Resources Data Bank will be a comprehensive, searchable database of resources for healthcare coverage in South Carolina. Resources will include:

- Healthcare access programs
- Community wellness programs
- Healthcare prevention and screening programs
- Faith-based health initiatives
- Non-profit agencies that provide health access services for free or at reduced rates

For each resource, the data bank will supply contact information, services provided, hours of operation, eligibility requirements and links to organization websites. The website will also link to other websites with resources for insured and uninsured such as the United Way, Nurse Line, MUSC Medicaid provider list, Healthy Greenville and SCDHHS.

Small Employer Health Insurance:
List of licensed small employer insurers
List of fully-insured Association Health Plans
List of community health centers that offer services to small employers
Description of small employer laws
Frequently Asked Questions

Community Calendar:

Health screenings, wellness, and/or disease management programs offered throughout the state
Faith-based community programs
Special Events

Media Center:
Articles regarding healthcare and the uninsured

The website will be maintained by the Office of Research and Statistics, South Carolina Budget and Control Board, and Palmetto Project, a private, non-profit organization.[xli] Palmetto Project has agreed to find continued funding to keep the website updated. The Office of Research and Statistics will continue to serve as the website administrator. The Department of Insurance will assist the project by updating the small employer insurance information as needed. Potential future partners may include private insurers, the United Way, disease-management organizations and provider associations.

South Carolina Department of Insurance Health Benefits Fairs

To complement the Business Forums, the South Carolina Department of Insurance held five Health Benefits Fairs throughout the state to allow small employers and individuals the opportunity to meet in an educational environment to discuss healthcare needs and possible solutions. Health Benefits Fairs included workshops and vendors from the community, including hospital-based programs, agents and brokers, health insurance companies and HMOs, community healthcare centers, Medicaid, the Department of Insurance's Consumer Services Division and local small business development centers.

Health Benefits Fairs were held in Columbia, Charleston, Greenville/Spartanburg, Hilton Head and Myrtle Beach. The lack of affordable healthcare coverage was cited as the number one issue facing small businesses. Additionally, there was a lack of awareness of the availability of community-based and public programs. For these two reasons, it was important to present information concerning both private and public insurance plans to the local communities. The goals of the Health Benefits Fairs were to:

- Provide a setting for small employers and employees to talk with insurers and agents;
- Provide educational workshops specifically designed to assist participants in managing their health benefits and costs;

- Provide an opportunity to meet with state regulators and learn what services are available; and
- Allow participants to provide feedback on the grant, policy options, and Health Benefits Fairs.

A short description of each Health Benefits Fair follows:

Columbia Health Benefits Fair:

The Columbia Health Benefits Fair was held on June 23, 2004 at the Embassy Suites Hotel in Columbia, South Carolina. The Health Benefits Fair was open between the hours of 11:00 a.m. and 7:00 p.m. Thirty-four (34) vendors were present and 36 participants attended. In addition to the vendors, seven presentations were held on the following topics:

- Supplemental Benefits
- Richland Care Community Health Program
- "Well on Your Way to a Healthy Business"
- Employer Health Plans through Community Health Centers
- Mini Med Products
- Health Benefit Costs
- Healthcare Savings Accounts

The local media covered the event live and interviewed vendors and participants. Eleven door prizes were awarded, all provided by participating vendors. Participants and vendors that attended the Health Benefits Fair had positive comments about the location, set up, and the number and quality of vendors. "More advertising" was the suggestion most often provided, although the Health Benefits Fair was widely advertised on radio, television and in the newspaper. Another popular suggestion was to decrease the number of hours the Health Fair was open.

Greenville Health Benefits Fair:

The Greenville Health Benefits Fair was held on July 7, 2004 at the Hyatt Regency in downtown Greenville, South Carolina. The Health Benefits Fair was open between the hours of 11:00 a.m. and 7:00 p.m. Thirty-four (34) vendors were present and 105 participants attended. In addition to vendors, we held a benefit panel discussion at noon and two additional presentations later in the day. The following topics were presented:

- Supplemental Benefits

- Mini Med Products
- Healthcare Savings Accounts
- Employer Health Plans through Community Health Centers
- Healthy Greenville

The Greenville Chamber of Commerce and the United Way assisted the Department of Insurance by agreeing to e-mail all of their members and contacts about the Health Benefits Fair. It was also widely advertised on radio, television and in the newspaper. Additionally, the local media interviewed SPG staff at the hotel the morning of the event, and returned later for live footage. Twenty-six (26) door prizes were awarded, all provided by participating vendors. Participants enjoyed the presentations and found them very informative. A common complaint was that the vendors left early. The vendors were pleased that the turnout had improved from the previous fair that was held in Columbia. However the vendors felt that the day was too long and again requested shorter hours for future Health Benefits Fairs. Vendors and participants expressed that more advertising would have increased participation.

Charleston Health Benefits Fair:

The Charleston Health Benefits Fair was held on July 22, 2004 at the Embassy Suites Convention Center in North Charleston, South Carolina. The Health Benefits Fair was open between the hours of 11:00 a.m. and 6:00 p.m. Thirty (30) vendors were present and 93 participants attended. In addition to vendors, we held a benefit panel discussion at noon and one additional presentation later in the day. The following topics were presented:

- Supplemental Benefits
- Mini Med Products
- Healthcare Savings Accounts
- Employer Health Plans through Community Health Centers
- Benefits and Cost

The local Chamber of Commerce sent out an e-mail invitation to promote the Health Benefits Fair to all of its members. The *Charleston Business Journal* put the date on their published calendar, *Skirt* magazine, as well as the local newspaper and radio programs, also advertised the event. Seventeen door prizes were awarded, all provided by participating vendors. Participants enjoyed the presentations and found them very informative. Prior to the Charleston Health Benefits Fair, the vendors were asked not to leave early, so there were no complaints about this issue. The

vendors were generally pleased with the turnout, but still felt that increased advertising would have helped attendance. Vendors suggested shorter hours for future Health Benefits Fairs as well as possibly partnering with another large event.

Hilton Head Health Benefits Fair:

The Hilton Head Health Benefits Fair was held on August 4, 2004 at the Arts Center in Hilton Head, South Carolina. The Health Benefits Fair was open between the hours of 2:00 p.m. and 6:00 p.m. Twenty-one (21) vendors were present and 82 participants attended. This was the only event not held in a hotel room and the small accommodations were perfect for the size of this event.

The local Chamber of Commerce sent out invitations to the Health Benefits Fair to all of its members. Seventeen (17) door prizes were awarded, all provided by participating vendors. Participants were generally satisfied with the event, stating that the event was informative and a great idea. Participants suggested they would have preferred more insurers/vendors, specifically more local vendors, as well as more information on workers' compensation and senior care.

The last two Health Benefits Fairs included a questionnaire to give the Department of Insurance an idea about who was attending. Most of the respondents heard about the Health Benefits Fair from the Chamber of Commerce, the radio or television. Seventy-six percent (76%) were insured and worked full time. Fifty-six percent (56%) of the respondents' employers offered insurance and 80% were eligible for his employer's plan. "Cost" (46%) was the number one reason cited for not having health insurance.

Myrtle Beach Health Benefits Fair:

The Myrtle Beach Health Benefits Fair was held on August 18, 2004 at the Kingston Plantation Embassy Suites, Myrtle Beach, South Carolina. The Health Benefits Fair was open between the hours of 2:00 p.m. and 6:00 p.m. Eighteen (18) vendors were present and 84 participants attended.

The Myrtle Beach and North Myrtle Beach Chambers of Commerce sent out e-mails about the upcoming Health Benefits Fair to all of their members. Seventeen (17) door prizes were awarded, all provided by participating vendors. Participants were satisfied with the event, stating that the vendors were professional, helpful and the booths were well staffed. Participants suggested

that future fairs include vendors who specialize in dental, individual plans, cafeteria plans and product liability.

Respondents to our survey stated that radio advertising was the most effective way of promoting the event. Sixty-eight percent (68%) were insured and 88% worked fulltime. Sixty-four percent (64%) of the respondents' employers did not offer health insurance and 73% were eligible for the employer's plan. "Cost" (60%) and "not available from employer" were the number one and two reasons for not having health insurance.

Outcome of the Health Benefits Fairs

Over 400 small employers, self–employed individuals and others attended the five Health Benefits Fairs in South Carolina. While the attendance was less than expected at first, overall attendance progressively improved. Most participants found the information provided to be helpful and meaningful. Moreover, attendees, participants and vendors suggested that the Health Benefits Fairs become annual events. Many vendors also suggested that the Health Benefits Fairs be held at the same time as another local business event. The South Carolina Department of Insurance agreed to work with interested parties in pursuing the possibility of annual Health Benefits Fairs.

Advertising was sufficient in quality and quantity. However, a longer advertising period may have resulted in better attendance. Additional lead-time would have enabled potential participants to better arrange their schedules. The cooperation of each local Chamber of Commerce was critical to the success of the event. In addition, the Department of Insurance utilized the membership lists from the Small Business Chamber of Commerce, the United Way and the South Carolina Association of Non-Profit Organizations.

A list of participating vendors is available at www.coveringtheuninsuredsc.org. This is a resource for the individuals who were not able to attend the Health Benefits Fairs and includes a list of over 100 vendors that serve small employers, self-employed individuals and the uninsured.

The National Health Insurance Symposium

The National Health Insurance Symposium was held in 2003 in Charleston, South Carolina to identify strategies to address issues

of health insurance affordability and availability within state insurance markets. This program followed and supplements the Insurance Regulation and Cost Containment Conference held in Chicago, Illinois. The purpose of the symposium was to discuss ways states could address the issues of availability and affordability in the health insurance market. The symposium focused on potential solutions to the issues of health insurance affordability and availability. A group of national speakers, industry participants and experts on health insurance policy were assembled to propose possible solutions or strategies states could implement to address the health insurance crisis in this country. The symposium was co-sponsored by the National Association of Insurance Commissioners.

4.1.1.3: Option 3--South Carolina Community Health Plan Act ("SCCHPA")

In an effort to assist uninsured patients obtain affordable healthcare, this policy option proposes a change in current law and would allow non-profit community-based healthcare programs to collect prepayment fees for the services they provide. In addition, these prepayment fees may be used for provider reimbursement and/or to increase the number of patients served by the community health plan. This policy option requires a legislative change.[xlii] The South Carolina Department of Insurance worked with the National Association of Insurance Commissioners (NAIC) to poll other states about similar programs. Unfortunately, no similar programs exist. However, an NAIC Model Act entitled *Prepaid Limited Health Service Organization Model Act* may be an excellent starting point for writing the new legislation.

The HIPAC determined that all eligible programs should be community-based and, as much as possible, the eligibility, plan design, prepayment fees, distribution system and provider reimbursement should be determined by each community's needs. In addition, the prepayment fees collected could be used to improve the facility, increase the patient population, improve administrative functions, develop a marketing strategy or to increase provider reimbursement. A number of legal and regulatory issues are being researched. The Department of Insurance is considering, among other things: (1) what current insurance laws will apply to the SCCHPA; (2) capital, surplus, reserves and other financial requirements; (3) what consumer protections are necessary; and (4) how the Department will regulate community health plans. The proposed legislation could

potentially change the way community health centers are regulated. Currently, the care provided by community health centers is not considered insurance.

The Department of Insurance is working closely with the existing non-profit community health programs to ensure that the needs of these programs are balanced with the regulatory requirements in the legislation. The Department plans to have the legislation completed in time for the 2005 legislative session.

This proposed legislation would assist community health plans in providing healthcare to uninsured individuals who are unemployed or ineligible for both Medicaid and Medicare. This group accounts for approximately 29% of the uninsured population. Additionally, this legislation will also help create programs for uninsured individuals between jobs who are not eligible, or who cannot afford, COBRA or state continuation.

4.1.1.4: South Carolina Statewide Communication Plan

The South Carolina Department of Insurance requested supplemental funds in 2003 to implement a statewide communication plan. Two goals were set for the Communication Plan.

1. Create awareness of the grant program and its progress by informing and educating the General Assembly, business leaders, agents, brokers and associated state departments of the uninsured demographics, the issues facing the uninsured, and the policy recommendations from the HIPAC.
2. Formulate a statewide communication plan to gain support for the proposed policy options and provide further analysis of the recommended changes to the healthcare delivery system.

The medium for educating South Carolinians included presentations, Business Forums, public service announcements, newspaper and magazine articles, radio programs, and a 30-minute program on South Carolina Educational Television entitled, "Paying the Premium, A Documentary about the Uninsured in South Carolina." In addition, a state-specific website was created to identify existing programs and provide a centralized site to search programs by eligibility and location.

Presentations were made to key associations and at seven Business Forums were held throughout the state in 2003. Attendance was good and participants ranged from agents selling individual and small group products, to people who were uninsured and out of work. A PowerPoint presentation that summarized the data and policy recommendations was provided, as well as a two-page summary of the grant research. There was a great deal of support for policy change to assist the medically uninsured both nationally and in South Carolina. The policy options recommended by the HIPAC were briefly described and participants were encouraged to keep in touch with the program by viewing the South Carolina Department of Insurance website.

It was during these Business Forums that the idea of statewide Health Benefits Fairs was discussed. Participants asked for additional information and a follow up to the Business Forums. It was determined that bringing small business owners and uninsured together with representatives of the private insurance and public healthcare systems to talk about healthcare options would be valuable. What we could not accomplish at the Business Forums (i.e., identifying existing programs, providing alternative products for small business, and providing more detail on the HIPAC's policy options) we were able to provide during the Health Benefits Fairs.

In addition to the Business Forums, the Department of Insurance created two public service announcements that were played on multiple radio programs. The first PSA previewed the uninsured issues and asked for personal stories from listeners. The second PSA highlighted a small employer story. Both PSAs requested listeners call the South Carolina Department of Insurance and to visit the Department's website for additional information.

The Director of the Department of Insurance was interviewed multiple times regarding the project data, analysis and recommendations. Articles were printed in Charleston's *The Post & Courier*, Columbia's *The State*, *USA Today*, *South Carolina Business Review*, and the *South Carolina Business Journal*. The grant staff was also interviewed for several local and national business radio programs.

The pinnacle of the Communication Plan was the completion of "Paying the Premium, a Documentary about the Uninsured in South Carolina". The 30-minute documentary aired statewide and showcased the many faces of the uninsured while discussing the various issues associated with healthcare and health insurance in

South Carolina. The documentary included data on the uninsured, expert testimonials and personal stories from South Carolina employers and employees. Representatives from state agencies, local businesses, the General Assembly and South Carolina citizens, were highlighted in the video. The HIPAC is hopeful that the video will be used for years to come to educate South Carolinians and to encourage policy change in South Carolina.

SUMMARY

One of the primary objectives of the State Planning Grant was to evaluate the cost and coverage impacts of a wide range of options for expanding health insurance coverage in the state. For each option, the HIPAC estimated the number of persons who could become insured and the cost. The options presented in this Section are those HIPAC believed would expand coverage to the greatest number of people at the lowest cost. The Medicaid expansion option could potentially expand coverage to 150,000 uninsured. Option 3—the South Carolina Community Health Plan Act—is a direct care model that should provide other uninsured people with basic healthcare services. This service delivery approach of community-based care builds on the local commitment of community healthcare organizations to assure access to everyone. This option emphasizes preventive care and provides assistance for other specialty services. The purpose of this proposed legislative option is to expand the availability of free or subsidized healthcare for needy individuals who continue to be uninsured and do not qualify for employment-based coverage. The prepayment fees should cover the costs of expanding services. No costs have been estimated at this time. One important task will be to inventory safety net providers throughout the state in order to develop more and improved healthcare access points. This inventory would then be available on www.coveringtheuninsuredsc.org
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SECTION 5

CONSENSUS BUILDING STRATEGY

5.1: Governance structure used in the planning process

The South Carolina Department of Insurance served as the lead agency and had primary responsibility for managing the grant project. The Department partnered with Office of Research and Statistics, SCDHHS and others to handle data collection and analysis for the project. In 2000, the Department of Insurance began meeting with members of the South Carolina General Assembly, to discuss ways to stabilize the small group health insurance market. This discussion evolved into conversations with other state agencies about expanding coverage for the working poor. This was difficult without state-specific data.

To ensure that the State Planning Grant project had input from all appropriate and interested parties, the Health Insurance Policy Advisory Committee (HIPAC) was created. The HIPAC was charged with assisting with data analysis and designing coverage expansion options to reduce the number of uninsured by improving access to health insurance coverage.

Our partners on this project include a coalition of representatives from the medical, legislative, insurance, and business communities. Members of the HIPAC include representatives from the following agencies:

Governor's Office
State General Assembly
South Carolina Office of Research and Statistics, Division of the Budget and Control Board
Clemson University and University of South Carolina
South Carolina Department of Health and Human Services
Managed Care Alliance
Medical and Hospital Association
Community Health Centers
Business advocates such as NFIB and the Small Business Chamber of Commerce
Department of Consumer Affairs
Primary Healthcare Association

State agencies involved with healthcare policy and other groups interested in issues affecting the uninsured were invited to participate. Affordable health insurance was an important issue for many members of our government. Consequently, we were able to secure the participation of members of our General Assembly. The HIPAC was an effective method of securing diverse input on a variety of issues. Discussion was sometimes spirited, but the process enabled the

Department to gain consensus on the policy options proposed. We also believe that the work of this Committee will assist the S.C. Commission on Healthcare Access with implementation of these policy options.

5.2: Methods Used to Obtain Input

Prior to applying for the State Planning Grant, the Department of Insurance created a team of health insurance experts to determine why small employer insurers were leaving the market. This team, under the leadership of the Department, reviewed health insurance mandates, competition, the rating law, and other appropriate small group insurance issues. Unfortunately, they were unable to find any clear and definite reasons for the current market situation. The formation of this team of experts was the first effort at data collection and initiated the Department's interest in obtaining a State Planning Grant to further study the issues.

The HIPAC was formed specifically to solicit input from the agencies, businesses, providers, consumer advocates, small business owners, legislators and other interested persons. Each member had an opportunity to provide information and recommendations based on their experience and expertise.

Through our formal data collection utilization activities, we obtained input through key informant interviews, focus groups, household and employer surveys. These data collection activities provided opportunity to gain insight from these groups, but also provided an opportunity to inform South Carolinians about the grant project and its objectives.

In addition, we conducted seven Business Forums, five Health Benefits Fairs and multiple presentations throughout the state and have talked to hundreds of people about the problems facing the uninsured. The PSAs and educational television program that aired also solicited input from viewers and listeners. Additionally, we collected many real life stories about families facing medical problems without insurance.

5.3: Activities Conducted to Build Awareness and Support

The South Carolina Department of Insurance requested supplemental funds in 2003 to be used for implementation of a statewide communication plan. Two goals were set for the Communication Plan:

1. Create awareness of the grant program and its progress by informing and educating the General Assembly, business leaders, agents, brokers, and associated state departments, of the uninsured demographics, the issues facing the uninsured, and the policy recommendations from the HIPAC; and

2. Formulate a statewide communication plan to gain support for the proposed policy options and provide further analysis of the recommended changes to the healthcare delivery system.

The media for educating South Carolinians included: the National Health Insurance Symposium held in Charleston, South Carolina; presentations; Business Forums; public service announcements; newspaper and magazine articles; radio programs and a 30-minute program on South Carolina Educational Television entitled *Paying the Premium, A Documentary about the Uninsured in South Carolina.* In addition, a state-specific website was created to meet the objective of identifying existing programs and creating a centralized site to search programs by eligibility and location.

Presentations to key associations and to seven Business Forums were held throughout the State in 2003. Attendance was good and participants ranged from agents selling individual and small group products to people who were uninsured and unemployed. There was a great deal of support for policy change to assist the uninsured both nationally and in South Carolina. The policy options recommended by HIPAC were briefly described and participants were encouraged to keep in touch with the grant through the South Carolina Department of Insurance website.

It was during these Business Forums that the idea of statewide Health Benefits Fairs was discussed. Participants were asking for additional information and a follow up to the Business Forums. It was determined that having a centralized location where citizens could come together with representatives of the private and public healthcare system to talk about options for the uninsured and small business would be invaluable. What we could not accomplish in the Business Forums (i.e., identifying existing programs, alternative products for small business, and providing more detail on the HIPAC's policy options) we were able to provide during the Health Benefits Fairs.

In addition to the Business Forums, the Department of Insurance kept the issue of uninsurance in the news. Two public service announcements were created and were played on multiple radio and television stations. The first PSA previewed the uninsured issues and asked for personal stories from listeners. The second PSA highlighted a small employer story. Both PSAs requested listeners call the South Carolina Department of Insurance and visit the Department's web site for additional information.

The Department of Insurance was interviewed multiple times regarding the project data, analysis and recommendations from the grant. Articles were printed in *The Post & Courier, The State Newspaper, USA Today, South Carolina Business Review, and the South Carolina Business Journal.* The grant staff was also interviewed for several local and national business radio programs, including Bill Bailey's, *It's Your Money*, radio broadcasts.

The highlight of the Communication Plan was the completion of *Paying the Premium, A Documentary about the Uninsured in South Carolina*. The 30-minute documentary aired statewide and showcased the many faces of South Carolina's uninsured while discussing the various issues associated with healthcare and health insurance. The program included data on the uninsured, expert testimonials and personal stories from South Carolina employers and employees. Representatives from state agencies, local businesses, the General Assembly and South Carolina citizens, were highlighted in the video. This video will be used for years to come to educate South Carolinians about the issues facing the uninsured.

5.4: Effect of Planning Effort on the Policy Environment

The State Planning Grant has brought a great deal of attention to the uninsured and the small employer insurance market these past two years. In fact, a proviso was signed by South Carolina Governor Mark A. Sanford this year to create a Commission on Healthcare Access to oversee the implementation of the HIPAC recommendations. Robert (Bob) Toomey, the Chairperson of the Commission, is a retired businessperson who has worked for State agencies, the legislature, and other businesses. The Department of Insurance will do a briefing at the Commission's first meeting. He and members of his Commission will attend the HIPAC's last meeting. A copy of the final report to HRSA will be reviewed at that time.

SUMMARY

The governance structure and SPG planning process were effective means of raising public awareness of health insurance, in general, and focusing attention on the uninsured. The SPG planning process has advanced the potential for expanding affordable health insurance coverage for state residents. The SPG provided state-specific data on the uninsured in South Carolina. This state-specific data was not previously available. This data challenged assumptions about the uninsured. Most uninsured South Carolinians are either self-employed or employed by a small business. The SPG has facilitated the development of policy options to expand health insurance coverage.

South Carolina, like many other states, faces a budget deficit. Leaders are currently addressing budget shortfall issues and the way services are provided. The feasibility of enacting some coverage programs in South Carolina would be enhanced if the federal government increased its share of funding in support of coverage expansion options or provided a little more flexibility in Section 1115 waivers.

SECTION 6

LESSONS LEARNED

6.1: The Importance of State-Specific Data

State-specific data was essential to the SPG project and the formulation of policy alternatives in South Carolina. SPG funds were used to identify the characteristics of the uninsured and the consequences individuals experience as a result of being uninsured. South Carolina collected both qualitative and quantitative data. The qualitative data included focus groups, key informant interviews, and direct feedback from Business Forums, Health Benefits Fairs, public service announcements (PSAs) and the educational television program. The input from South Carolinians, both uninsured and insured, was invaluable to our policy development. There is nothing more powerful than South Carolinians telling their personal stories. The SPG staff collected stories and opinions about employment based coverage, the individual market, affordable coverage, adequate benefits, access and medical debt. The SPG staff also heard from consumers who lost coverage due to lay-offs, illness, and Medicaid ineligibility.

The qualitative data was a valuable tool. It helped us educate others about the plight of the uninsured and to gain support for the grant program. It also provided individuals an opportunity to brainstorm about solutions to health insurance rate stability, insurance access and affordability. The qualitative data humanized the statistics.

The quantitative data included a Household Survey and Employer Survey. The response rate for both surveys, particularly from uninsured households, was above average and therefore credible. The data also revealed that there are significantly more uninsured South Carolinians than the census data reports. Regional and some county specific data provided information as to the geographic location of the majority of uninsured South Carolinians. The data collected under this grant directly impacted the uninsured populations targeted in our policy recommendations.

The data supported our initial supposition that for small groups, particularly with less than 10 employees, affordability of healthcare coverage is the number one reason why employers do not provide group health insurance. It is also the reason employees do not elect to participate in sponsored plans when offered. The data was used to garner statewide support for the HIPAC policy recommendations.

6.2: Effective Data Collection Activities

Using the South Carolina Office of Research and Statistics was the most cost effective means of data collection. The Office of Research and Statistics serves as the state repository for statistical information. Existing information used for the

purposes of the grant was available at no cost. The Employer Survey was probably the most cost-effective survey we completed because we had great response rates. However, there are some concerns about the validity of the sampling frame. Both surveys helped clarify that uninsurance is not *just* a low-income family problem; it has expanded into the middle-income families. Most uninsured are employed and work for employers who do not offer health benefits.

The Household Survey was the centerpiece of our research and contains the most reliable information. It was also the most expensive survey instrument to administer. However, the state-specific data and the larger sample size of uninsured households made the expense of the survey well worth it.

The qualitative data was very effective and relatively inexpensive. It is particularly valuable when combined with the data from the Employer and the Household Surveys. None of these data collection activities would have been as beneficial without the others.

6.3: Ineffective Data Collection Activities with the Least Pay-off

The only data collection activity that was not conducted was the employee survey. This survey was dropped after it was determined that we were not able to get a reliable data set to draw from that had all of the information we needed (employer size, employee home address, etc.). More than likely, this survey would have overlapped the results of the Household Survey. It did not prove critical to our overall data objectives.

Additionally, we did not conduct as many employer and employee Focus Groups as we had originally planned due to cost. Again, this change did not impact our overall data objectives.

Finally, a Utilization Survey was administered but had too few respondents. The names and addresses were obtained from emergency room data collected on individuals who used the emergency room for non-emergency services. The low response was most likely due to the addresses being incorrect and/or not updated.

6.4: Recommendations to Improving Data Collection

Our approach to the survey was a great blend of quality and frugality that allowed us to collect sufficient data for specific needs within the relatively tight confines of the budget. Through telephone contacts misclassified businesses were eliminated from the Employment Security Commission sampling frame. The telephone contacts also assisted employers by answering questions about the survey. Recommendations include the following:

- Contract with local experts in medical data collection to save on data collection activities that have already been done.

- Contract with individuals and agencies that do not have a pre-conceived view of the problem and/or solution.
- Send the employer survey from the Department of Insurance to help increase the response rate.
- Hold an agent/broker focus group. Agents have valuable information about what employers and employees want in terms of product and what they are willing to pay.
- Attend as many of the focus groups as possible as a silent observer to ensure that appropriate information is being collected and that the administrator is not leading the groups.
- Contact other SPG project managers before work begins to avoid common problems and pitfalls.

6.5: Additional Data Collection Activities Needed

It was helpful for South Carolina to develop a cost impact to the healthcare system for the uninsured. We were able to have this study done through supplemental funding from the State Planning Grant program. The average cost of the uninsured per South Carolinian was approximately $2,000 annually. Having this number provided us with the answer to the question "why is this important to me?" People with health insurance are paying more in premiums because of uncompensated care and all of us are paying more in taxes to cover uninsured individuals. This is even more of an issue when an uninsured individual becomes seriously ill and needs hospitalization because they have had to delay services.

It is our opinion that the Household and Employer Surveys should be repeated every three to five years following any significant policy change. Re-surveying will ensure that the implementation was successful. It also provides a chance to compare demographic changes in the uninsured. There is no long-term plan in place to seek funding for the required data collection follow-up. This will be a recommendation made to the Commission on Healthcare Access.

6.6: Organization or Operational Lessons Learned

The South Carolina Department of Insurance recommends the following to future grantees:

- **Start early and ask for help.** We anticipated completing our data collection in six to nine months. In fact, it took over one year to complete.
- **Find a mentor within the State Planning Grants program.** Take advantage of the work that has already been done. Look for someone who is in a state with similar issues, demographics, and/or policy recommendations.
- **Do not try to read all of the information available on the uninsured**. Try to concentrate only on the data, studies, articles, etc. that are

applicable to your state or similar states. It is not possible to read all of the available information.

- **Accept all interested parties on the policy advisory committee so that no one feels like they have been left out of the process.** This helps with building consensus.
- **Keep your working groups to no more than six people who have time and are willing to work.** The project manager will need help to research and develop all the policy recommendations that come out of the policy advisory committee.

As a result of the SPG, South Carolina is now considering proposed legislation that would enable community health organizations to collect prepayment fees to offset the cost of providing healthcare services. This proposed legislation is based on the NAIC Prepaid Limited Health Services Organization Model Act. It will be a limited benefit plan.

6.7: Key Lessons about Your Insurance Market and Employer Community

Fifty-three percent (53%) of businesses under 10 employees do not provide health insurance and 39% with 11 to 20 employees do not provide health insurance. Not only are employees working for small employers less likely to be offered employer-sponsored health insurance; but also when coverage is offered, the premiums will be higher than the premiums for plans offered by larger employers. If one of these employees applies for coverage in the individual market, he may be turned down or face pre-existing condition limitations. Premiums will be based on the health of each family member and can be unaffordable for people with chronic health conditions, even when these conditions are under control. There are simply not many affordable health insurance options for employees of small businesses. Unfortunately, 62% of licensed businesses in South Carolina have less than four employees, 17% have five to nine employees, and 10% have 10 to 19 employees.

Many small employers do not think that health insurance is critical for hiring and retaining employees. Employers who classify their business as construction, professional, retail, hotel/motel and manufacturing are least likely to provide health insurance. Employers in the Pee Dee and Low Country regions are least likely to provide health insurance.

The insurers interviewed were all members of the South Carolina Managed Care Alliance and recommended that mandated coverage or further rate restrictions not be considered. It was their collective opinion that the products marketed were competitive and met the market's needs. They were also concerned that HIPAC would develop a product that competed with the private insurance market particularly if it provided subsidies. It is not likely that insurers will oppose the policy options recommended by the HIPAC.

Because the focus of South Carolina's SPG was expanding coverage within the small group health insurance market, the involvement of the small business community was critical. This is a very important issue to small businesses. As a result, they were engaged in the process and assisted with the development of survey instruments and other data collection activities.

6.8: Political and Economic Environment Changes

Several changes occurred in South Carolina over the past year that could have potentially changed the direction of the grant. In 2003, we had a change of leadership and a Republican governor was elected. Governor Mark A. Sanford re-appointed Ernst N. Csiszar, the Director of Insurance, and has supported the work of the HIPAC. Governor Sanford also signed a proviso to form the Commission on Healthcare Access. The Commission's goal is to implement the policy recommendations of the HIPAC. Most recently, Director Csiszar resigned. A permanent replacement has not yet been determined. However, the change in leadership has not had any negative impact on the state planning grant.

The other significant changes during the last legislative session involved budget cuts and subsequent changes in Medicaid. Due to current economic conditions in South Carolina, the HIPAC considered limiting state funding for every policy recommendation. As such, most recommendations require little or no state funding.

6.9: Changes in Project Goals During the Grant Period. The project goals have become more defined, but have not changed. The SPG staff remained focused on finding affordable solutions to expand health insurance coverage within the small group market. Health Benefits Fairs were added to the original action plan after it became clear that small businesses and individuals were not aware of the newer types of products available in the private insurance market. These more affordable products included consumer-driven health plans, benefit plans that increased out-of-pocket expenses, and reduced benefit (mini-meds) plans. In addition, the South Carolina Primary Healthcare Association put together a plan to offer the services of community health centers to employers who were not providing coverage to their employees. There are 37 community health centers throughout South Carolina participating in this program. In addition to these programs, private insurers, agents, brokers, Medicaid, and the Department of Insurance's Consumers Division all participated in the five Health Benefits Fairs.

6.10: South Carolina's Next Steps

As of September 1, 2004, the end of the grant period, each policy recommendation from the HIPAC has been referred to a different state agency. The Commission on Healthcare Access will oversee implementation and further

development of the HIPAC recommendations. Listed below are the options and the agency primarily responsible for its implementation.

- **The South Carolina Small Employer Health Plan Option**
  Responsible Party: South Carolina Department of Health and Human Services.

  It has been recommended that DHHS apply for a State Planning Grant in 2005 to cover the costs of developing and pricing a Medicaid Expansion Program for working adults.

- **South Carolina Community Health Plan Act ("SCCHPA")**
  Responsible Party: South Carolina Department of Insurance.

  Legislation is currently being drafted to share with statewide non-profit community health centers.

- **Healthcare/Insurance Education**
  Responsible Party: The Office of Research and Statistics, Budget and Control Board.

  The Office of Research and Statistics has agreed to maintain the website, www.coveringtheuninsuredsc.org. Palmetto Project has agreed to look for annual funding to keep the website updated and useful.

- **Oversight:** The Governor's Commission on Healthcare Access will provide the necessary oversight.

SECTION 7

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1: Coverage Expansion Options Requiring Federal Waiver Authority

One of the purposes of the SPG program is to provide recommendations to the federal government regarding the expansion of health insurance coverage. What follows are the recommendations from the HIPAC for your consideration.

- ***Continue funding for State Planning Grants and allow the grant money to be used for certain developmental and implementation projects***. South Carolina has benefited from the state-specific data secured through the data collection process. States could progress more quickly at expanding health insurance coverage to the uninsured if SPG funds could also be used for demonstration or implementation purposes. South Carolina, like many other states, is trying to recover from an economic downturn. For this reason, the options for expanding coverage were limited to those that would not depend specifically upon state funding. To implement Option 1, South Carolina must secure funding for an implementation/demonstration project from private grant sources. It is hoped that by the conclusion of the demonstration project state funds will be available to support this expansion option. This option is based on a successful demonstration project conducted by the state in the early 1990's.
- ***Provide more money to the State for Medicaid and Medicaid expansion programs.*** Additional funds would help the states expand coverage to uninsured individuals who meet the eligibility guidelines.
- ***Simplify the application process for waiver funding***. The application and application review process is cumbersome and discourages many states from applying
- ***Consider increasing the federal portion of the federal/state (currently 70/30) match to encourage states to address issues of the uninsured (e.g., change to 80/20)***.
- ***Explore different options to improve access to medical savings accounts for small and large employer groups.*** Medical savings accounts tend to be restrictive and do not provide the tax breaks that other tax-preferred accounts provide such as HSAs, because they only apply to small business or self-employed coverage. The annual deductible also tends to be lower.
- *Add Community Health Plans to the HIPAA definition of creditable coverage. If community health plans are permitted to offer a limited benefit plan as set forth in Option 3, coverage under such a plan should qualify as creditable coverage for HIPAA purposes. The HIPAC members proposed that HIPAA definitions be amended accordingly.*

The South Carolina Small Employer Health Plan Option (Medicaid expansion) requires approval of a Section 1115 Waiver. Due to state budgetary constraints,

South Carolina does not have state funding available to commit to its small employer health plan option. In lieu of state funds, this state is proposing that employer and employee contributions be used as matching funds for the program. This would enhance the state's ability to expand coverage to the uninsured.

7.2: Additional Support Requested from the Federal Government

The Commission on Healthcare Access will implement the HIPAC policy recommendations. Additional funding for development of the small employer insurance product described in Option 1 is needed. It will be critical to the completion of South Carolina's waiver application. In addition, South Carolina would like to resurvey the 150,000 eligible uninsured to determine what impact, if any, the Small Employer Health Plan option has had on expanding health insurance coverage to the uninsured and whether this expansion option has had any impact on the annual cost of the uninsured.

HEALTH INSURANCE POLICY ADVISORY COMMITTEE

During the past several years South Carolina, like many states, has been faced with decreased budgets, a tough economy for employers and employees, and an increase in the medically uninsured. It was an opportune time for the South Carolina Department of Insurance to look for creative coverage options for the medically uninsured.

In late 1992 the Department of Insurance was awarded a state-planning grant from the United States Department of Health and Human Services in the amount of $1.2 million. This grant was intended to collect and analyze data that will enable South Carolina to recommend initiatives designed to expand access to affordable health care coverage based on state specific data on the uninsured. Data Collection, managed by the S.C. Department of Insurance and the S.C. Office of Research and Statistics, included a Household Survey, Employer Survey, Utilization Survey, Focus Groups and Key Informant Interviews.

To insure that the grant project had input from all appropriate and interested parties, the Health Insurance Policy Advisory Committee (HIPAC) was created. HIPAC was tasked to analyze the data and help develop and design strategies that will reduce the number of uninsured by improving access to health insurance coverage. HIPAC was chaired by the SPG Project Manager, Viki Fox. An alphabetical list of the other HIPAC members and their companies/agencies is listed below. We appreciate all of their hard work on this meaningful project.

HIPAC Members

The Honorable Thomas Alexander, South Carolina Senate
Mac Bennett, Central Carolina Community Foundation
Sue Berkowitz, South Carolina Appleseed Justice Foundation
Tom Brown, Palmetto Richland Memorial Hospital
Thomas Churan, Clemson University
Michael Crino, Clemson University
Joe Davenport, Davenport Diversified Consultants
Christopher Dixon, SC Primary Health Care Association
Charles Duke, Clemson University
Larry Fernandez, Department of Health and Human Services
Michael Fields, National Federation of Independent Business
Casey Fitts, M.D., Tri-County Project Care
Gwendolyn L. Fuller, SC Department of Insurance
Erin Hardwick, SC Association of the Non-Profit Organizations
Brenda Hart, Senate Finance Committee
Jim Hart, SC Managed Care Alliance
Jim Head, SC Hospital Association
Frank Knapp, S.C. Small Business Chamber of Commerce
Kelly Danias, SC Medical Association
Melanie Matney, Palmetto Richland Memorial Hospital

Tambra Medley, SC Hospital Association
Bob Oldendick, Institute for Public Service and Policy Research
David Patterson, Office of Research and Statistics
Brandolyn Thomas Pinkston, SC Department of Consumer Affairs
Ann Roberson, SC Department of Insurance
Tim Rogers, House Ways and Means Committee
Frank Rupp, Tri-County Project Care
Linda Sharkey, Department of Health and Human Services
Ken Shull, SC Hospital Association
Rob Smith, House Labor, Commerce and Insurance Committee
The Honorable Daniel Tripp, South Carolina Representative
Ken Trogden, CommuniCare
Mary Tyrell, Office of Research and Statistics
Sue Walton, Senate Banking and Insurance Committee
Regina West, Senate Finance Committee
Tim Wilkes, SC Small Business Chamber of Commerce
Lathran Woodward, SC Primary Health Care Association

SPG Staff[xliii]

Gwendolyn L. Fuller
Principal Investigator

Patricia Priester
Program Coordinator

Viki Fox
Project Manager

Audrey Muck
Program Coordinator

Pierre Barakat Novak[xliv]
Co-Project Manager (2003)
Consulting

Donna
NovaRest

DOI Staff Support

Ann Roberson
Cindy Little

ADDITIONAL RESOURCES

Websites: www.coveringtheuninsuredsc.org

South Carolina Department of Insurance:
www.doi.state.sc.us
Click on blue box entitled "Health Insurance Grant"

South Carolina Department of Health and Human Services:
www.dhhs.state.sc.us
Report of Major Coverage Groups

Centers for Medicare and Medicaid Services:
www.cms.hhs.gov
South Carolina Waiver Programs and Demonstrations

Office of Research and Statistics,
South Carolina Budget & Control Board
http://www.ors2.state.sc.us/abstract/chapter11.html
South Carolina Statistical Heath Data

Other: State Coverage Initiatives:
http://www.statecoverage.net

AcademyHealth:
http://www.academyhealth.org

Kaiser Family Foundation:
http://www.kff.org

Health Resources and Services Administration
U.S. Department of Health and Human Services
http://www.hrsa.gov

[i] This represented a 100% sampling.
[ii] *See* Appendix 1 Baseline Information, Table 56: Uninsured Business Type, p. 90.
[iii] See *Textiles: An Industry in Crisis*, South Carolina Workforce Trends, South Carolina Employment Security Commission, Special Edition (May 2003). This publication reports that since 1973 South Carolina has lost 100,000 textile manufacturing jobs. The number has decreased from 160,000 in 1973 to 58,000 in 2002.
[iv] *See* Stoll, Kathleen and Kim Jones, *Health Care: Are you Better Off Today Than You Were Four Years Ago?* A Report by Families USA (September 2004).
[v] S. C. Code Ann. § 38-71-1310 *et seq*. (2002).
[vi] S. C. Code Ann. § § 38-71-840 through 38-71-880 (2002).
[vii]The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is funded by The Robert Wood Johnson Foundation to help states monitor rates of health insurance coverage and to understand factors associated with uninsurance. SHADAC provides targeted policy analysis and technical assistance to states that are conducting their own health insurance surveys and/or using data from national surveys.
[viii] The final response rate for this instrument was low. The low response rate was attributed to poor or incorrect addresses for self-pay and indigent patients.
[ix] Rosenfeld, Isadore, Ph.D. and Dotson Rader, *Can You Pay For Your Healthcare? Parade Magazine* (August 15, 2004).
[x] *See generally*, South Carolina Department of Health and Environmental Control, http://www.scdhec.gov/hs/comhlth/risk/statistics.htm#tobacco.
[xi] *Joblessness Down in January*, Workforce Trends Newsline,S.C. Employment Security Commission, (January 2004); http://www.sces.org/lmi/news/January_2004.pdf.
[xii] *See* Regopoulos, S. T., *Employers Shift Rising Health Care Costs to Workers: No Long-term Solution in Sight*, *Center for Studying Health System Change*, Issue Brief No. 83, (May 2004).
[xiii] *U.S Census Bureau: State and County QuickFacts*. Data derived from Population Estimates, 2000Census of Population and Housing, 1999 Census of Population and Housing, Small Area Income and Poverty Estimates, County Business Patterns, 1997 Economic Census, Minority and Women-Owned Business, Building Permits, Consolidated Federal Funds Report, 1997 Census of Governments; http://quickfacts.census.gov/qfd/states/45000.html.
[xiv] The reason for the insignificant difference in the uninsured percentages between Caucasians and African Americans is unknown at this time.
[xv] These figures may not reflect updated Census projections.
[xvi] This may also impact the eligibility criteria, location of the center and the need for bi-lingual staff and printed materials.
[xvii] *See* Appendix I: Baseline Information, Table 54: Duration of Uninsurance, p. 88.
[xviii] *See* Appendix I, Baseline Information, Table 55: Employer Size, p. 89.
[xix] Agency for Healthcare Research and Quality Medical Expenditure Panel Survey. For the 2000 Medical Expenditure Panel Survey Insurance Component tables; *See also* www.meps.ahrq.gov/date_public_tables.html.
[xx] *See South Carolina Rural Health Report*, Health and Demographics, Office of Research and Statistics, South Carolina Budget & Control Board; http://www.ors2.state.sc.us/rural_health.htm.
[xxi] *See* Appendix I: Baseline Information, Table 60: Percentage of Part-time and Seasonal Workers, p. 92.
[xxii] *See* Appendix I: Baseline Information, Table 65: Effect On Ability to Attract Employees, p. 97.
[xxiii] Agency for Healthcare Research and Quality Medical Expenditure Panel Survey. For the 2000 Medical Expenditure Panel Survey Insurance Component tables; *See also* www.meps.ahrq.gov/date_public_tables.html.
[xxiv] *See* Regopoulos, S. T., *Employers Shift Rising Health Care Costs to Workers: No Long-term Solution in Sight*, *Center for Studying Health System Change*, Issue Brief No. 83, (May 2004).
[xxv] *See* Appendix I: Baseline Information, Table 63: Level of Contribution, p. 96.
[xxvi] *See* Appendix I: Baseline Information, Table 64: Percentage of Employees Offered Coverage Who Participate, p. 96.

[xxvii] However, a bare-bones policy with no mandates may violate S.C. law. See S.C. Code Ann. § 38-61-10 *et seq.* (2002).
[xxviii] This includes the self-employed who have no employees.
[xxix] South Carolina law already mandates insurers offer a basic and standard benefit plan. *See* S.C. Code Ann. §38-71-1360(A)(1) (2002).
[xxx] This number has declined significantly since 1997.
[xxxi] *See* Kofman, M., J.D., *Health Savings Accounts: Issues and Implementation Decisions for States, State Coverage Initiatives*, Issue Brief, Vol. V, No. 3 (September 2004).
[xxxii] *Id* at p. 3.
[xxxiii] *Id* at p. 3.
[xxxiv] *Id* at p. 4.
[xxxv] The Arkansas Minimum Benefit plan is a limited benefit insurance product without insurance mandates.
[xxxvi] The name is on the split in premiums payments being split three ways: 1/3 Employer; 1/3 Employee; 1/3 Federal match. State funding of Medicaid can come from a number of sources: tax revenues; tobacco settlements; other taxes; and transfers from other units of government (IGT**).** Third share programs use federal matches to IGTs. IGTs come from a variety of sources. A non-profit entity accepts the federal money and pays the matching premium to the insurer. Product is designed to result in a $150 monthly premium. Dependents are usually added at employee expense without the match. Decisions made by the community leadership include: plan design; requirement for businesses to participate; size; length of time in business; prior coverage; average wage; location; requirements for employees to participate, etc.
[xxxvii] The South Carolina Health Access Program (SCHAP) was a successful demonstration project conducted in South Carolina in the early to mid-1990's. The South Carolina Department of Health and Human Services obtained a Section 1115 Medicaid waiver that was used to design and implement this program. SCHAP provided coverage to families through small businesses in two counties. The program was successful and was only discontinued because the small groups could not find an entity to take over the administration of the program after the four-year demonstration project ended. This program addressed access and affordability of health care coverage for the working poor in our State, a target population for this project.
[xxxviii] While factors such as 1) the cost of prescription drugs; 2) the expense of new medical technology; 3) medical malpractice awards and 4) the cost of uncompensated care certainly contribute to the cost of health insurance, they are not the sole reasons health insurance premiums are rising.
[xxxix] *See* Stoll, Kathleen and Kim Jones, *Health Care: Are you Better Off Today Than You Were Four Years Ago?* A Report by Families USA (September 2004).
[xl] The U.S. spends more of its gross domestic product on healthcare than any other major industrialized country. In 1960, healthcare expenditures were 5% of the GDP; by 2000, that figure had grown to more than 13%.
[xli] Palmetto Project is supported through foundations, corporations and individual donations. It specializes in locating funding and writing grants for new and existing programs.
[xlii] The collection of pre-payment fees may constitute premium thereby requiring entities selling such services to be licensed as insurers under South Carolina law.

[xliii] Pierre Barakat worked with the SPG project during its first year.
[xliv] Donna Novak provided actuarial consulting services to the SPG team.